	CHART OF COVERED/NOT COVERED CONDITIONS AND SERVICES (SEE ADDITIONAL EXCLUSIONS AT END OF CHART.)	BENEFITSPLUS	REGULAR PLAN
Emergency Health Service (i.e., Emergency Room)	Notification required if results in an inpatient stay. Participant must call within 48 hours or as soon as reasonably possible. Otherwise non-notification penalty would apply.	Covered	Covered
Emergency Service Outside of the United States	Charges for emergency treatment only for services received outside of the United States, limited to reimbursement of Covered Charges at the United States dollar exchange rate as of the date the charge was incurred and urgent care for those who are working in El Salvador for the purpose of repair or transport of planes.	Covered	Covered
Enteral Nutrition	Covered when sole source of nutrition OR Covered when a certain nutritional formula treats a specific inborn error of metabolism	Covered	Covered
Experimental, Investigational or Unproven Services	Experimental, investigational and/or Unproven services are excluded. The fact that an Experimental, investigational or Unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental, investigational or Unproven in the treatment of that particular condition.	Not Covered	Not Covered
Family Planning	Oral contraceptives covered under pharmacy plan Devices covered under medical plan	Covered	Covered
Foot Care	Hygienic and preventive maintenance foot care. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Examples include: treatment of flat feet; treatment of subluxation of the foot; shoe inserts; arch supports; shoes (standard or custom), lifts and wedges. shoe orthotics covered if prescribed by a Physician.	Not Covered	Not Covered
Hearing Aids	▪ Charges for hearing aid purchase, fittings, and replacements are limited to a $3,500 maximum every 36 Months.	Covered	Covered
Hearing Care	▪ Covers hearing screenings up to age 17 as part of routine preventive office visit	Covered	Not Covered
Hospital Confinements	Pre-authorization is required. ▪ Notification is required for elective admissions (five days before the admission), non-elective admissions (within one day of admission), and emergency admissions (within 48 hours or as soon as reasonably possible). ▪ Benefits available for services and supplies received during the inpatient stay in a Semi-private Room (two or more beds)" ▪ Room and Board and routine nursing while confined in a Hospital for a Semi-private room at the Semi-private rate of the Hospital. If the Hospital is an all-private room Hospital, the plan will pay Room and Board expenses up to the prevailing Semi-private rate of area Hospitals. Special Charges are reviewed as claims separate from Room and Board claims and will be covered only if coverage is provided for in this Plan.	Covered	Covered
Injections	Available for injections received in a Physician's office when no other health service is received (such as allergy and immunotherapy).	Covered	Covered
Inpatient Hospital Physicians Services	Pre-authorization required.	Covered	Covered
Intensive Care Unit	Pre-authorization required. Services and supplies received during the inpatient stay. ▪ For those Hospitals that charge separately for intensive nursing care, the specific charge for intensive nursing care is covered. ▪ For those Hospitals that combine charges for Room and Board and Intensive nursing care, the charge for the intensive nursing care, in excess of the standard Semi-private room rate, is covered.	Covered	Covered
Laboratory Expenses	Diagnostic test (Outpatient, Inpatient, office or independent facility)	Covered	Covered

	CHART OF COVERED/NOT COVERED CONDITIONS AND SERVICES (SEE ADDITIONAL EXCLUSIONS AT END OF CHART.)	BENEFITSPLUS	REGULAR PLAN
Medical Supplies and Equipment—Covered	• Norplant and Depo Provera. • Intrauterine devices (IUDs), diaphragms, oral contraceptives. • Prescription drugs as provided through the Medical Program. • Drugs which require a written prescription of a Doctor, which must be dispensed by a licensed pharmacist or Doctor, which are approved by the U.S. Food and Drug Administration and which are prescribed in accordance with their U.S. Food and Drug Administration approved use or have been favorably recognized for use with the particular condition or indication by one of the following: • The American Medical Association Drug Evaluations • The American Hospital Formulary Service Drug Information • The United States Pharmacopoeia Drug Information, or • Clinical studies, the results of which have been published in a major peer reviewed medical or scientific journal in the U.S. or Great Britain. In no event will this include a drug for a particular condition that has been determined by the U.S. Food and Drug Administration to be Experimental, Investigational, Unproven or contraindicated for that condition, even though the U.S. Food and Drug Administration may have approved the drug for other uses. • Blood and other fluids to be injected into the circulatory system. • Artificial limbs and eyes for loss of natural limbs and eyes and replacements, if Medically Necessary. • Lens, each eye (contact or frames) immediately following and because of cataract surgery only. • Casts, splints, trusses, braces, crutches, surgical dressings and custom-made orthotics. • Insulin and related supplies, colostomy sets. • Rental of Hospital-type equipment for kidney dialysis for the personal and exclusive use of the patient. The Claims Administrator also will consider as eligible all charges for supplies, materials and repairs necessary for the proper operation of such equipment and reasonable and necessary expenses for the training of a person to operate and maintain the equipment for the sole Benefit of the patient. • Durable Medical Equipment • Diabetic education and nutritional counseling. Services must be rendered by a Physician or licensed nutritional counselor. Educational materials and books are not covered. • Purchase or rental fees (not to exceed the purchase price) of Hospital-type medical equipment for other than kidney dialysis, including wheelchair, Hospital bed, equipment for the treatment of respiratory paralysis, and equipment for the use of oxygen. This does not include luxury Hospital-type medical equipment when standard equipment is appropriate for the patient's condition. • Repairs and adjustments of covered Hospital-type medical equipment provided that the repairs or adjustments are needed due to wear in the equipment or a change in the patient's condition and if it is less costly for the repair or adjustment than to purchase the equipment. • Diabetic strips and syringes • Compression stockings if prescribed by a Physician	Covered	Covered
Medical Supplies and Equipment – Not Covered	Some prescribed or non-prescribed medical supplies and some disposable equipment. Including: (including Jobst stockings to treat varicose veins), gauze and dressings, ace bandages, and urinary catheters. (This exclusion does not apply to: ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies, disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Diabetic Supplies, diabetic supplies for which Benefits are provided as described under Diabetic Supplies.) • Tubings, nasal cannulas, connectors, and masks except when used with Durable Medical Equipment • The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage, or gross neglect • The replacement of lost or stolen Durable Medical Equipment • Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items that are not specifically identified under Ostomy Supplies	Not Covered	Not Covered
Midwife	Midwife must be licensed or certified in accordance with the requirements of the state or jurisdiction of practice, practicing within the scope of the license or certification and rendering a service covered under the plan.	Covered	Covered
Naturopaths		Not Covered	Not Covered
Newborn Care Inpatient	Newborns are automatically covered for 31 days after the birth. To continue coverage after 31 days, the Life Event Form and required document showing proof of birth must be completed and submitted to the Health & Wellness Team within 30 days of the date of the birth. Includes room, board, Physician charges and circumcision	Covered	Not Covered

	CHART OF COVERED/NOT COVERED CONDITIONS AND SERVICES (SEE ADDITIONAL EXCLUSIONS AT END OF CHART.)	BENEFITSPLUS	REGULAR PLAN
Nutrition	Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy, nutritional counseling for either individuals or groups, except as identified under Diabetes Services. Food of any kind. Foods that are not covered include but are not limited to: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay; and other dietary and electrolyte supplements. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.	Not Covered	Not Covered
Nutritional Counseling	The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when: education is required for a disease in which patient self-management is an important component of treatment; and there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional. Some examples of such medical conditions include: coronary artery disease; congestive heart failure; severe obstructive airway disease; gout (a form of arthritis); renal failure; phenylketonuria (a genetic disorder diagnosed at infancy); and hyperlipidemia (excess of fatty substances in the blood).	Covered	Covered
Obesity Surgery	The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following are true: ▪ You have a minimum Body Mass Index (BMI) of 40; or ▪ You have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity. Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery. Network Coverage Only; Out-of-Network – No Coverage Pre-notification of Personal Health Support required. **Surgical treatment of severe/morbid obesity, as defined by NIH (National Institutes on Health), must meet the following** **Covered Charges:** Charges for adults age 23 and older, as determined by Physician based on Claims Administrator's clinical guidelines for coverage. **Expenses Not Covered:** Bariatric surgical procedures in non-adult patients, closure of the mouth by wiring the teeth, gastric wrap and Duke Procedure, intragastric balloon, jejunoil bypass, suction lipectomy (lipo suction, any body part) are not covered charges for the treatment of morbid or severe obesity, due to the inadequate clinical evidence of safety and/or efficacy in published peer-reviewed scientific literature. ▪ In addition, the plan does not cover cosmetic surgical procedures as the result of severe or morbid obesity surgical procedures. ▪ Services rendered by Non-Network Providers are not covered.	Covered: Choice Plus Plan & HSP Not Covered: Choice Plan C	Not Covered
Occupational Therapy	▪ Services must be performed by a licensed therapy Provider under the direction of a Physician. ▪ Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.	Covered	Covered
Orthoptic Therapy	Eye exercise therapy	Covered	Covered
Ostomy Supplies		Covered	Covered
Outpatient Surgery		Covered	Covered
Personal Care, Comfort or Convenience	Television, telephone, beauty/barber service, guest service, supplies, equipment and similar incidentals for personal comfort. Examples include air conditioners; air purifiers and filters; batteries and battery chargers; beauty/barber shop; computers to assist in communication and speech; dehumidifiers and humidifiers; ergonomically correct chairs; non-Hospital beds, comfort beds, motorized beds and mattresses; Breast pumps (if You are enrolled in BenefitsPlus, this exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA)) requirement; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners; electric scooters; exercise equipment and treadmills; guest services; hot tubs, Jacuzzis, saunas and whirlpools; medical alert systems; music devices; personal computers; pillows; power-operated vehicles; radios; strollers; safety equipment; telephone; television; vehicle modifications such as van lifts; video players; and home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).	Not Covered	Not Covered
Physician Visits (General)		Covered	Covered
	CHART OF COVERED/NOT COVERED CONDITIONS AND SERVICES (SEE ADDITIONAL EXCLUSIONS AT END OF CHART.)	BENEFITSPLUS	REGULAR PLAN

Physical Appearance	▪ Cosmetic procedures including pharmacological regimens, nutritional procedures and treatments, scar and tattoo removal or revision procedures (such as Sal abrasion, chemosurgery and other skin abrasion procedures) skin abrasion procedures performed as a treatment for acne ▪ Replacement of an existing breast implant if the earlier implant was performed as a cosmetic procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed a mastectomy). ▪ Physical conditioning programs such as athletic training, body building, exercise fitness, flexibility, and diversion or general motivation. ▪ Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. ▪ Wigs for hair loss regardless of the reason. ▪ Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.	Not Covered	Not Covered
Physical Therapy	▪ Services must be performed by a licensed therapy Provider under the direction of a Physician. ▪ Benefits are available only for the rehabilitation services that are expected to result in significant improvement in the patient's condition within two Months of the start of treatment, whether in-Network or Out-of-Network. ▪ Treatment of benign gynecomastia (abnormal breast enlargement in males).	Covered	Covered
Private Duty Nursing Outpatient	Private duty nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).	Covered	Covered
Prosthetic Devices	▪ Pre-authorization is required. ▪ Covers devices that replace a limb or body part including: Artificial limbs, Artificial Eyes, Breast prosthesis (as required by the Women's Health and Cancer Right's Act of 1998) ▪ If more than one prosthetic device can meet the participant's functional need, benefits are available for the most Cost Effective prosthetic device. ▪ The device must be ordered by, provided by, or under the direction of a Physician. ▪ Only custom made orthotics are covered. ▪ Medical plan discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.	Covered	Covered
Pulmonary Rehabilitation Services	▪ Services must be performed by a licensed therapy Provider under the direction of a Physician. ▪ Benefits are available only for the rehabilitation services that are expected to result in significant improvement in the patient's condition.	Covered	Covered
Radiation Therapy		Covered	Not Covered
RAP (Radiology, Anesthesiology, & Pathology)	Radiology, Anesthesiology, Pathology (Lab): This option will always pay lab, x-ray and anesthesia at the network level for inpatient and outpatient facility claims.	Covered	Covered
Reconstructive Procedures	▪ Pre-authorization is required. ▪ For services when a physical impairment exists and the primary purpose is to improve or restore physiological function. Services include surgery and other procedures associated with an injury, Sickness, or Congenital Anomaly. The fact that the physical appearance may change or improve as a result of the procedure(s) does not automatically qualify the surgery as Cosmetic when a physical impairment exists and the surgery restores or improves function. ▪ Cosmetic Procedures are excluded from coverage except that, benefits are provided for cosmetic or reconstructive treatment or surgery; - Due solely to an accidental bodily injury. - Due solely to surgical removal of all or a part of the breast tissue or other tissue as a result of an illness, or - Due solely to a birth defect of a covered child under the age of 18 - Procedures that correct an Anatomical Congenital Anomaly without improving or restoring physiological function are considered cosmetic. - The fact that a participant may suffer psychological consequences or socially avoidant behavior as a result of an injury, Sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. **Reconstructive Procedures include:** -Breast reconstruction following a mastectomy related to breast cancer -Reconstruction of the non-effected breast to achieve symmetry -Breast Prosthesis	Covered	Covered
Rehabilitation Services (Inpatient)	Pre-authorization is required	Covered	Covered

	CHART OF COVERED/NOT COVERED CONDITIONS AND SERVICES (SEE ADDITIONAL EXCLUSIONS AT END OF CHART.)	BENEFITSPLUS	REGULAR PLAN
Rehabilitation Services (Outpatient)	Rehabilitation services must be performed by a licensed therapy Provider, under the direction of a Physician. The Plan provides short-term out-patient rehabilitation services for the following types of therapy: physical therapy; occupational therapy; speech therapy by a speech therapist*; pulmonary rehabilitation therapy; cardiac rehabilitation therapy; manipulative treatment; post-cochlear implant aural therapy; or cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident. * Benefits for speech therapy are paid for services of a licensed speech therapist for treatment given to a child under age three whose speech is impaired due to one of the following conditions: infantile autism; development delay or cerebral palsy; hearing impairment; or major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed manipulative treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive manipulative treatment. Benefits are limited to 30 visits per Calendar Year for manipulative treatment (1 visit per day). These limits only apply to the Choice Plus Plan and HSP. These visit limits apply to In-Network Benefits and Out-of-Network Benefits combined. The Plan excludes any type of therapy, service, or supply for the treatment of a condition that ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.	Covered	Covered
Services Provided Under Another Plan	Charges for any accidental bodily injury or illness that arises out of or in the course of any employment with any employer, or any occupation for which You are entitled to benefits under any Workers' Compensation law or Occupational Disease law, or any settlement from Workers' Compensation. Charges for losses that are due to war or any act of war, whether declared or undeclared, or from engaging in the commission of a crime or participation in a riot. Charges incurred from a service-related disability for treatments, services or supplies provided by an agency of the United States government or a foreign government agency, unless the exclusion of such benefits is prohibited by law.	Not Covered	Not Covered
Speech Therapy	**ALL PLANS:** There is no designated visit limitation, however all visits are subject to Personal Health Support review. Services must be performed by a licensed therapy Provider under the direction of a Physician. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits are available only for the rehabilitation services that are expected to result in significant improvement in the patient's condition from the start of treatment. **For dependents under age 3:** Benefits are paid for services of a licensed speech therapist for treatment given to a child under age three whose speech is impaired due to one of the following conditions: infantile autism; development delay or cerebral palsy; hearing impairment; or major congenital anomalies that affect speech including, but not limited to, cleft lip and cleft palate. **Speech therapy for dependent over 3 Years of age:** The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from injury, Sickness, stroke, cancer, or a congenital anomaly, or is needed following the placement of a cochlear implant. Autism is not covered. Learning disabilities and developmental delays excluded (except for children under age 3, as listed). **HSP ONLY: Speech therapy for dependent over 3 Years of age:** The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from injury, Sickness, stroke, cancer, autism spectrum disorders or a congenital anomaly, or is needed following the placement of a cochlear implant.	Covered	Covered
Sterilization	Pre-authorization required Voluntary sterilization or vasectomy Excludes charges for the reversal or attempted reversal	Covered	Covered
TMJ	Covers surgery and appliances. Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology. Benefits are not available for charges for services that are dental in nature. Regular Plan: Limited to a $1,000 lifetime maximum. Covered: Charges for the diagnosis, treatment, or tests for temporomandibular joint dysfunction (or by any name called)	Covered	Covered
Travel	Health services provided in a foreign country, unless required for emergency health services. Travel or transportation expense, even though prescribed by a Physician	Not Covered	Not Covered

	CHART OF COVERED/NOT COVERED CONDITIONS AND SERVICES (SEE ADDITIONAL EXCLUSIONS AT END OF CHART.)	BENEFITSPLUS	REGULAR PLAN
Urgent Care Centers	Covers services provided in an Urgent Care Center. If services to treat urgent care are provided in a Physician's office, benefits are payable through the Physician office benefit.	Covered	Covered
Vision Care	Covered charges for tests and treatment due to illness or injury only. Glasses and Contact Lenses are only covered if immediately following and because of cataract surgery. **Excluded:** ▪ Routine Eye Exams. ▪ Purchase cost of eye glasses or contact lenses. ▪ Fitting charge for eye glasses or contact lenses. ▪ Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism Including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery.	Covered	Covered
X-rays	X-rays (other than dental), lab tests and other diagnostic services.	Covered	Covered

	CHART OF COVERED/NOT COVERED CONDITIONS AND SERVICES	BENEFITSPLUS	REGULAR PLAN
ADDITIONAL EXCLUSIONS	Sex Change / Transformation Surgery—and related counseling. Growth hormone therapy—unless medically necessary. Domiciliary care Liposuction Chelation therapy, except to treat heavy metal poisoning. Cosmetic or reconstructive surgery (except as specified above). Custodial Care Respite Care except as covered for hospice Reiki cures Psychosurgery Medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Appliances for snoring Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer.—i.e. the LeForte surgical procedure will be covered if approved through Personal Health Support or Personal Health Support Personal Trainer Naturalist Holistic or Homeopathic Care Charges which are not medically appropriate. Charges in excess of reasonable and customary. Charges due to a pre-existing condition, except to the extent payable as described in this Plan. All types of special education and training. Birth control unless specifically listed as a covered expense. Charges for confinement in a skilled nursing facility which do not meet the requirements of the plan, i.e. custodial care. Medical and surgical treatment for excessive sweating (hyperhidrosis) unless medically necessary. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when: Required solely for purposes of: career, education, sports or camp, travel, employment; insurance, marriage or adoption; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; or Required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Health services received after the date Your coverage under the Plan ends, including Health services for medical conditions arising before the date Your coverage under the Plan ends. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Health education classes, including but not limited to asthma, smoking cessation, and weight control classes. In the event that a Provider waives Copayments, Coinsurance, and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which any amounts due are waived. Charges in excess of Eligible Expenses or in excess of any specified limitation. Non-surgical treatment of obesity, including morbid obesity. Services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations when the services are considered to be dental in nature, including oral appliances. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing. Charges for any service, supply, prescription drug or procedure related to smoking cessation. This is covered on BenefitsPlus Only. Charges for equipment or supplies made or used for physical fitness, athletic training or general health upkeep. Any charges higher than the actual charge. The actual charge is defined as the Provider's lowest routine charge for the service, supply or equipment. Any charge for services, supplies or equipment advertised by the Provider as free. Any charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency. Any charges prohibited by federal anti-kickback or self-referral statutes. Any additional charges submitted after payment has been made and Your account balance is zero. Any outpatient facility charge in excess of payable amounts under Medicare. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services. Outpatient rehabilitation services, spinal treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning	Not Covered	Not Covered

	- or to prevent a medical problem from occurring or reoccurring. ▪ Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies. ▪ Speech therapy to treat stuttering, stammering, or other articulation disorders. ▪ Charges incurred after the date covered under the plan ceases. This applies even though the charges are related to a condition which began while covered. ▪ Charges for any experimental, investigation or unproven services, supplies, tests or treatments and any related expenses. Unless provided in the plan—flu shots and other inoculations and treatments that an individual may receive as a result of being exposed to a particular disease. Rabies vaccines and tetanus shots will be covered in conjunction with accidental injuries. ▪ Charges for biofeedback (or any name called). ▪ Charges for health checkups or routine physical examinations, unless provided under this plan. ▪ Charges for psychological testing, except neuropsychological testing if approved by Personal Health Support. ▪ Charges for the banking of umbilical cord placenta and teeth bone marrow ▪ Pornography ▪ Gender Identity Disorder (GID)		

BENEFITSPLUS HSP AND HSA FREQUENTLY ASKED QUESTIONS:

1. What is the difference between the Health Savings Plan (HSP) and Health Savings Account (HSA)?

The Health Savings Plan is a new medical option in the BenefitsPlus program. The HSP has lower upfront Monthly contributions, but significantly higher Deductibles, higher Coinsurance requirements, and a different payment structure for prescription drug coverage compared to the other two BenefitsPlus options.

The Health Savings Account is a tax-advantaged savings account available only to those enrolled in the Health Savings Plan. You may save on taxes through your contributions into the account, interest earned on those contributions, and qualified medical expenses paid from the account.

HEALTH SAVINGS PLAN (HSP)

2. Is the Health Savings Plan the same as a traditional PPO (Preferred Provider Organization)? No. The Health Savings Plan works similarly to a PPO in some ways—coverage for In-Network and Out-of-Network Providers, Deductibles, and Coinsurance requirements; however, there are many differences. For example, under the Health Savings Plan you must meet the entire Deductible before you receive any benefits for sick doctor's visits and the prescription drug coverage is quite different. Read below for additional information.

REQUIREMENTS

3. Is the Health Savings Plan available in BenefitsPlus and the Regular Plan? No. The Health Savings Plan option is **only** available in BenefitsPlus. If you are currently enrolled in the Regular Plan, but would like to enroll in BenefitsPlus for 2013, then you must complete a Benefits Request for Program Change Form. You must allow at least 24 hours for the Form to be processed before you may use the online enrollment tool to select the Health Savings Plan.

4. Are there any eligibility requirements to enroll in the Health Savings Plan? Yes; but the eligibility requirements are the same as the eligibility requirements for the other medical options. See the annual enrollment Guide for additional information on eligibility.

5. Can I enroll in the Health Savings Plan if I have a Committed Partner? Yes. You may participate if you have a Committed Partner just as you can with all medical options at Southwest; however, the value of the benefits attributable to the Committed Partner program will be imputed to your income and you will be subject to applicable tax withholding on this amount. See the Committed Partner Benefits Policy for additional information on Committed Partner benefits.

6. What is the upfront Monthly contribution for the Health Savings Plan option? The upfront Monthly contributions for the Health Savings Plan are lower than the upfront Monthly contributions for the other BenefitsPlus options. See the annual enrollment Guide for specific amounts that apply to your family.

QUALIFIED PREVENTIVE CARE

7. Are my preventive care services covered in the Health Savings Plan option? Under the Health Savings Plan option, In-Network qualified preventive care is covered at 100% *without* having to satisfy the Deductible. Out-of-Network qualified preventive care will be covered at 100% up to the amount considered "reasonable and customary."

8. What are considered qualified preventive care services? Preventive care services include annual wellness exams, immunizations, well child exams, physicals, and mammograms.

9. Are my preventive prescription drugs considered "preventive care services"? No, preventive drugs are not considered preventive care services. Preventive drugs are not covered at 100%. See the Prescription Drug Coverage section below for additional information on prescriptions.

DEDUCTIBLE

10. What is a Deductible? A Deductible is the annual amount you must pay before the Health Savings Plan will begin covering a portion of your medical costs. Your upfront Monthly contributions do not count toward your Deductible.

11. What are the Deductible amounts in the Health Savings Plan for In-Network and Out-of-Network benefits? The annual Deductibles for In-Network and Out-of-Network benefits in the Health Savings Plan option are the same amount.

- Employee Only coverage: $1,500 per Year
- All levels of Family coverage (i.e., Employee plus Spouse, Employee plus Children, Employee plus Family, or any Committed Partner coverage level): $3,000 per Year

12. Does the Deductible in the Health Savings Plan work differently than the other BenefitsPlus options? Yes. Unlike the other medical coverage options, under the Health Savings Plan, the Employee Only Deductible and the Family Deductible are completely separate. No one in the family is eligible to receive benefits until the entire Family Deductible amount has been met. One Family member can satisfy the $3,000 Deductible or a combination of Family members can satisfy the $3,000 in total—but, the full $3,000 *must* be met before the plan will pay for any one individual Family member.

13. Do I have to meet separate Deductibles for In-Network and Out-of-Network coverage? No. All medical expenses incurred, both In-Network and Out-of-Network, apply to the Deductible. Unlike the other medical coverage options, you are not required to satisfy separate Deductibles for In-Network and Out-of-Network coverage. Under the Health Savings Plan, you only have one Deductible amount to meet, and once you reach your Deductible then the Plan will begin contributing toward your healthcare costs.

14. Do I have to meet the annual Deductible for prescriptions? Yes. Except for certain preventive medications, before the Plan will pay for any of the cost for your prescriptions, you must meet the annual Deductible. See the Prescription Drug Coverage section below for additional information on prescriptions.

15. If I go to the doctor for a sick visit (not preventive care) on the first day of the Plan Year (January 1), what will I have to pay? You will pay for the full cost of your care on the first day of coverage. If you go to an In-Network Provider then you will receive the In-Network discounted rates for the services you receive, so you will be paying less than someone "off the street." The amount that you pay will be credited to your Deductible. Once you meet your annual Deductible, then the Plan will start contributing toward the cost of your care through Coinsurance.

Coinsurance

16. What is Coinsurance? "Coinsurance" is a term used to describe when you and the Plan each pay a portion of the cost of your health care expenses. The Health Savings Plan will begin paying "Coinsurance" after you have satisfied the annual Deductible—you will pay a portion of your care, and the Plan will pay a portion.

17. What are the Coinsurance amounts in the Health Savings Plan? After you meet the annual Deductible, the Plan will pay 80% Coinsurance for In-Network benefits (you will pay 20%) and 60% for Out-of-Network benefits subject to Reasonable and Customary limitations (you will pay 40% plus any amounts deemed not Reasonable and Customary). The Reasonable and Customary limitation in the Health Savings Plan is the same limitation that applies to other benefit coverage options.

18. Do these Coinsurance percentages apply to all health care services? No. The Health Savings Plan Coinsurance coverage amounts only apply to benefits covered under the Health Savings Plan option. They do not apply to benefits not covered under this option (e.g., infertility treatments). In addition, Coinsurance does not apply to preventive care services as outlined above nor do they apply to prescriptions which have their own coverage amounts. See the Prescription Drug Coverage section below for additional information on prescriptions.

Out-of-Pocket Maximum (OOP Max)

19. What is an Out-of-Pocket Maximum? The Out-of-Pocket Maximum is the maximum amount of Coinsurance you will pay out of your own pocket. Once you have reached this amount, the Plan will begin paying 100% of your Covered Charges. However, if you use Out-of-Network services, Providers, or facilities, then your Out-of-Network benefits are subject to a "Reasonable and Customary" limitation which means that you may pay more than the Out-of-Pocket Maximum.

20. What is the Out-of-Pocket Maximum under the Health Savings Plan option?

In-Network	Out-of-Network*
Employee Only: $4,500	Employee Only: $6,750
Family: $9,000	Family: $13,500

**Subject to "Reasonable and Customary" limitations.*

21. Are the upfront contributions or the Deductible counted toward the Out-of-Pocket Maximum? No, your upfront contributions and your Deductible are *excluded* from the Out-of-Pocket Maximum.

22. In 2013, what is the maximum amount I will pay even with a high cost claim or catastrophic event? The total amount you will pay in the HSP in one plan Year is the sum of your upfront payroll contributions, the Deductible, the Out-of-Pocket Maximum, penalties for failure to obtain pre-notification of services, and non-Covered Charges. In addition, all Out-of-Network benefits are subject to a "Reasonable and Customary" limitation which means

that you could pay **more** than the Out-of-Pocket Maximum amounts listed above if you use Out-of-Network services, Providers, or facilities.

23. Must I meet both the In-Network and Out-of-Network Out-of-Pocket Maximums before the Plan begins paying 100% of my care? No, all expenses paid by you apply to both In-Network and Out-of-Network Out-of-Pocket Maximums—they are considered to "cross apply." You do not have to meet each one individually; however, the Out-of-Network Out-of-Pocket Maximum is higher, so before your Out-of-Network expenses are covered at 100%, you must pay more out of your own pocket. In addition, all Out-of-Network benefits are subject to a "Reasonable and Customary" limitation which means that you could pay more than the Out-of-Pocket Maximum amounts listed above if you use Out-of-Network services, Providers, or facilities.

PRESCRIPTION DRUG COVERAGE

24. What are the prescription drug benefits under the Health Savings Plan option? Unlike the other medical options, prescription drugs (excluding preventive drugs) are subject to the medical Deductible under the Health Savings Plan option before the Plan begins covering any portion of the cost of your prescriptions. You will be responsible for the full cost of your prescription drugs until you reach the Deductible. After you satisfy the deducible, you will pay 20% Coinsurance up to the Out-of-Pocket Maximum.

25. What is the coverage for preventive drugs? Medications on a specified list of preventive drugs are covered at 80% (you pay 20% Coinsurance) *before* the Deductible is met. The Deductible is waived for this particular list of drugs. You may find this list on SWALife>About Me>My Benefits>Information and Forms.

26. Who makes the determination on what is considered "preventive" and what is not? The Department of Treasury issues guidelines on the drugs considered preventive for high Deductible health plans with a Health Savings Account (HSA)—like our Health Savings Plan.

27. Does the Coinsurance for preventive drugs count towards my Deductible or Out-of-Pocket Maximum? Your Coinsurance amount does **not** apply toward the Deductible because the Deductible is waived for this specified list of medications; however, your Coinsurance amount **does** apply to the Out-of-Pocket Maximum.

28. Are there drug "tiers" in the Health Savings Plan, such as generic, preferred, non-preferred? No. In contrast to the other medical coverage options, under the Health Savings Plan option, there are no specified drug tiers with varying Coinsurance requirements. Non-preventive drugs (generic or brand-name) are subject to the Deductible and then 20% Coinsurance up to the Out-of-Pocket Maximum. You may be able to save money by using generic alternatives when available.

INFERTILITY TREATMENT AND APPLIED BEHAVIORAL ANALYSIS THERAPY

29. Are infertility treatments covered under the Health Savings Plan option? No. The only medical coverage option that provides coverage for infertility treatment is the BenefitsPlus Choice Plus Plan option.

30. Is Applied Behavioral Analysis (ABA) Therapy covered under the Health Savings Plan option? Yes. Applied Behavior Analysis (ABA) therapy for autism spectrum disorder is **only** covered under the Health Savings Plan option. The annual Deductible, Coinsurance, and Out-of-Pocket Maximum requirements apply to ABA therapy just as they apply to other treatment.

31. Are there any requirements I must satisfy for my ABA Therapy to be covered? All services for ABA Therapy for both in and Out-of-Network Providers require pre-notification; otherwise, coverage will be denied. Under the Health Savings Plan option, ABA Therapy (both in-In-Network and Out-of-Network) is generally only available from ABA agencies that employ both the Board Certified Behavior Analyst that develops the ABA treatment plan and the paraprofessionals that provide the actual ABA Therapy. To access benefits for autism coverage and meet the pre-notification requirement, call Clear Skies at (800) 742-8911.

HEALTH SAVINGS ACCOUNT (HSA)

ELIGIBILITY REQUIREMENTS

32. Do you have to be enrolled in the Health Savings Plan (HSP) to be eligible for the Health Savings Account (HSA)? Yes. You **must** be enrolled in a qualified high deductible health plan (HDHP) in order to open a Health Savings Account. The Health Savings Plan is the only qualified high deductible health plan offered at Southwest Airlines.

33. What eligibility requirements are there to open a Health Savings Account (HSA)?

1. You may ONLY have medical coverage under a qualified high deductible health plan (HDHP)—the Southwest Health Savings Plan.
   - You may not have coverage under a spouse's non-HDHP.
   - You may not be enrolled in Medicare (Part A or B), TRICARE or TRICARE for Life, even as secondary coverage. (If you are eligible for Medicare, but not enrolled, you are eligible to contribute to an HSA.)
   - You must not have received Veteran Administration (VA) Benefits (medical or prescription drug) within three Months of making any contribution to your Health Savings Account.
2. You may not be claimed as a dependent on someone else's tax return.
3. You, and your spouse (if any), may not contribute to a Healthcare Flexible Spending Account (including Southwest's Health Care FSA). However, you may contribute to a Dependent Care FSA.

34. Do any eligibility requirements apply to my Spouse? No. Eligibility requirements for the HSA only apply to the Employee.

35. What if my spouse is enrolled in Medicare or is receiving VA Benefits? You are eligible to open and contribute to a Health Savings Account because the eligibility requirements only apply to you, the Employee. You may still use the money in your HSA to pay the cost of qualified medical expenses for your Spouse, and you may contribute up to the Family limit as long as you enrolled your Spouse in the Health Savings Plan.

36. Am I still eligible to open a Health Savings Account if I receive pension (monetary) benefits from the Veterans Administration (VA)? Yes. You are ineligible to open and contribute to an HSA only if you receive medical or prescription drug benefits from the VA.

37. Is there an IRS limitation on the amount of income I can earn and still be eligible to open an HSA? No. There are no IRS income limitations restricting participation in an HSA.

38. If I enroll in the Health Savings Plan during annual enrollment intending to open a Health Savings Account (HSA), and then later find out I do not meet the eligibility requirements to open a Health Savings Account (HSA), can I change my medical plan enrollment option? No. If you enroll in the Health Savings Plan intending to open a Health Savings Account, but then determine you are not eligible for the Health Savings Account, you will not be able to change to another medical option until annual enrollment for 2014.

39. May I contribute to my HSA after I retire? Yes, provided you meet eligibility requirements for an HSA as described above.

40. May I contribute to my HSA if I am enrolled in Medicare? No.

CONTRIBUTIONS TO MY HEALTH SAVINGS ACCOUNT

Contribution Limits

41. How much can I contribute to my Health Savings Account (HSA)? The IRS determines the amount that may be contributed to a Health Savings Account each Year. For 2013, you may contribute $3,250 for Employee Only coverage and $6,450 for Family coverage. If you will be 55 Years old or older at any point during the Year, then you may contribute an additional $1,000 as a "catch-up" contribution.

42. Is my spouse also eligible to contribute an additional $1,000 "catch-up" contribution? If your spouse is also 55 Years old or older, then your spouse may be eligible to establish a separate HSA and make a "catch-up" contribution to that account.

43. Will Southwest be contributing anything into my Health Savings Account? No. For 2013, Southwest will not make contributions to your HSA.

44. Who can make contributions into my Health Savings Account? Anyone can make contributions into your account. However, you (the account holder) will benefit from the tax savings on the contribution—not the person who contributed the money.

45. What if I have more than one HSA? You may contribute to any HSA; however, it is your responsibility to ensure that your annual contributions do not exceed IRS limits. Contributions made by your family members or any other person may count toward your total annual contributions. You should consult with your personal tax advisor for additional assistance to ensure that you do not exceed IRS limits.

46. What if my spouse is also covered by a qualified high Deductible health plan and has an HSA through his employer? If your spouse is also covered by a qualified HDHP and has an HSA through his employer, then your contributions and his contributions when added together, regardless of to which HSA they were contributed, may not exceed the Family limit.

47. What happens if my contributions exceed the annual limit and I contribute too much to my HSA(s)? Your excess contributions may be subject to standard income tax rates plus a six percent penalty. You may be able to avoid the penalty if you correct the over-contribution prior to your tax filing deadline (generally, April 15th of the following Year). If you would like to request a refund of amounts over the limit contributed to your HSA with OptumHealth Bank, then you may complete and mail or fax a withdrawal/distribution form (available at www.optumhealthbank.com) to OptumHealth Bank. Earnings on the excess amount are also taxable.

48. Will my contributions withheld via payroll deduction be stopped automatically when I reach my applicable annual limit? Yes, provided, that your only contributions are made by you through payroll deduction to your account at OptumHealth Bank. You are responsible for ensuring that you do not exceed the contribution limit. If you make contributions to your account in addition to payroll deductions or to other accounts or if other individuals make contributions to your account or other accounts, then there is no guarantee that the contributions will stop before you reach the limit and you may be subject to the penalty described above.

49. How much can I contribute to the Health Savings Account if I have a Committed Partner? The HSA limits are determined based on your coverage level in the medical plan—the Health Savings Plan. If you have a Committed Partner covered by the Health Savings Plan, then you have a coverage level with more than one person so you may contribute up to the Family limit of $6,450.

50. What are the coverage limits if my coverage in the Health Savings begins mid-Year (i.e., other than January 1st, e.g., an AirTran transitioning Employee)? As long as you your coverage in the Health Savings Plan is effective before the first day of December of the Plan Year, then you are eligible to contribute the full annual amount to your HSA up to the IRS limits described above provided you continue to participate in the Health Savings Plan (or another qualified high deductible health plan) for the remainder of the Plan Year as well as the entire following Year. During this time, you may not have other health care coverage that would make you ineligible to contribute to an HSA.

51. What if I contributed the maximum annual amount to my HSA at the beginning of the Year, but my coverage in the Health Savings Plan ended mid-Year? If you do not have coverage on December 1st (as described in the question above), then you are only eligible to contribute to your HSA for the time you were covered by the Health Savings Plan (or another qualified high deductible health plan). You can calculate your allowed amount by pro-rating your maximum contribution — for Employee Only or Family coverage — for the part of the Year you were covered by a high deductible plan. You can arrange to withdraw your excess contribution as described above.

52. Does my annual limit change if my coverage changes from "Employee Only" to "Employee plus Spouse" during the Year? Yes. Your contribution limit is determined based on your medical coverage level that is in effect on December 1st of the Plan Year. If you have "Employee plus Spouse" coverage on December 1st, then you may contribute up to the Family level.

53. Can my Committed Partner open his or her own Health Savings Account? Your Committed Partner may be eligible to open his or her own Health Savings Account if he or she has coverage in the Health Savings Plan. You should consult your personal tax advisor for additional information.

How to Make Contributions to your HSA

54. How do I make contributions to my Health Savings Account? You may either (i) choose to have Southwest deduct your HSA contributions directly from your paycheck, in which case you must open your own account with OptumHealth Bank (see details below under HSA Bank Options), or (ii) choose to make direct contributions (for example, by personal check) to your HSA in which case you may open a Health Savings Account with the bank of your choice.

55. If I decide to make pre-tax payroll deductions, how do I elect the amount to contribute to my HSA? You will make your contribution election PER PAY PERIOD through the online enrollment tool available on SWALife>About Me> My Benefits> annual enrollment. During annual enrollment, you will be able to go directly to this tool and make your election by selecting the radio button next to "Health Savings Account" and then "Edit this Plan" at the bottom of the screen.

56. How much can I contribute to my HSA each pay period? Each Year you may choose to contribute any amount per pay period up to the IRS annual limit. Your contribution amounts do not have to be equal throughout the Year, and you may change, start, or stop your contribution amount during the Year.

Note, however, that you may only use amounts in your HSA to pay for or reimburse for qualified medical expenses incurred *after* you open your account.

57. How do I change my HSA contribution amount withheld through payroll deductions? To change your contribution amount during 2013, you must call the Benefits Department at (800) 551-1211 or SDN 4997 to "unlock" your HSA contribution. Once "unlocked," you may log in to SWALife>About Me> My Benefits> HSA Election to change your contribution amount.

58. May I contribute to my HSA with OptumHealth Bank other than by payroll deduction? Yes. After your account is established, you will be able to login to your HSA account through www.optumhealthbank.com and arrange to make a deposit to your HSA from another bank account, such as a savings or checking account, one time or on a recurring basis. You may also mail a check directly to OptumHealth Bank by using a contribution/deposit form available at www.optumhealthbank.com.

59. Will contributions made directly to my HSA—not through payroll deduction—be subject to income tax? Contributions made to an HSA that do not exceed IRS limitations are not subject to income tax; however, the only way to make contributions using "pre-tax" money is through payroll deduction. If you make deposits directly to your HSA, then you will be using "after-tax" money, meaning that the amount will be included in your income that is subject to tax withholding on your paycheck. Contributions not made via payroll deduction can be itemized on your tax return filing and are considered an "above-the-line" deduction such that you may not have to pay federal income tax. You will, however, still pay FICA taxes on amounts contributed directly to your HSA.

60. Can I roll the money from my IRA into my HSA? Yes. You may conduct a once in a lifetime roll over from your IRA into your HSA to help seed your account. This roll over counts toward your Yearly contribution limit. At this time, you may not roll money from your HSA into your IRA.

61. May I make contributions to my HSA if I am no longer covered by a qualifying HDHP? No. You may only contribute to an HSA when you are covered by a qualifying HDHP; however, you may continue to use amounts on deposit in your HSA to pay for qualified medical expenses for as long as there is money in the account.

Timing for Contributions

62. When will my paycheck deductions for my HSA contributions start? You cannot make contributions into your HSA until the first of the Month coinciding with or following active coverage in the Health Savings Plan. For example, for those enrolling during annual enrollment, your coverage in the Health Savings Plan will begin on January 1, 2013. The first contribution to your Health Savings Account will not be payroll deducted until at least January 5, 2013—the first paycheck for 2013. Your contributions will **only** begin being deducted from your paycheck *after* you have opened your HSA with OptumHealth Bank.

63. What if I do not receive a paycheck? Will any contribution amount be sent to my HSA? If you do not receive a paycheck, then no contribution will be made to your HSA for that pay period. This "missed" contribution will not be automatically "made up" on a future paycheck. You may want to consider changing your contribution election to make up for any missed contributions from missed paychecks.

64. When will my contributions be posted to my Health Savings Account? In most cases, your contributions will be posted to your Health Savings Account on the applicable pay day.

65. When will my funds be available in my account to use for a qualified expense? OptumHealth Bank has indicated that your funds will be available on the day following deposit. In most cases, this should be one to two business days following each pay day.

HEALTH SAVINGS ACCOUNT BANKING DETAILS

66. Which bank will administer my Health Savings Account? You may choose any bank to open your HSA. If you would like to use pre-tax payroll deductions to make your contributions, then you **must** open an account with OptumHealth Bank.

67. If I choose to do payroll deductions, does Southwest open my account with OptumHealth Bank? No. You are responsible for opening your own HSA by logging on to www.optumhealthbank.com and completing a short online application.

68. When should I open my Health Savings Account? If you enroll in the Health Savings Plan and would like to open an HSA, then you should do so as soon as possible. You may not use your HSA to reimburse yourself for medical expenses incurred before your account is opened.

69. Do I need any specific information in order to open my account with OptumHealth Bank? Yes. You will need to provide certain personal information (such as name, address (cannot be a PO Box), social security number) as well as Southwest's Group number—**199409**. OptumHealth Bank will contact you directly if additional information is needed to open your account.

70. Who owns my Health Savings Account? You own your HSA!

71. Does the money I have in my HSA roll over from Year to Year, or do I lose the money at the end of the Year? The money rolls over Year to Year. You do not lose the money in the HSA. It is your money.

72. Is my HSA FDIC insured? Yes, your HSA is FDIC insured up to the amount you have contributed. If you choose to invest the money in the HSA, then your investments are not FDIC insured. If you would like additional information, please talk to your bank.

73. Will I be able to access my Health Savings Account online? Most banks provide an online option. If you open your account with OptumHealth Bank, then you may log on to www.optumhealthbank.com to manage your account. You may make online payments and track your spending.

74. What fees are associated with the Health Savings Account at OptumHealth Bank? Accounts at OptumHealth Bank are subject to a Monthly maintenance fee to cover use of the OptumHealth Bank HSA Debit MasterCard and online bill payment. You may refer to the OptumHealth Bank fee schedule that is included with the OptumHealth Bank welcome kit that OptumHealth Bank will mail to your home address. If you select another bank, then you should ask whether any fees will apply to your HSA.

75. Can I open separate HSA accounts for my dependents? No. You may only open a Health Savings Account in your own name; however, you may use amounts in your HSA to pay for the qualified medical expenses for your eligible dependents.

76. What happens to my HSA when my employment with Southwest ends? Your HSA is in your name and belongs to you! It is your bank account and you may keep it even after your employment with Southwest ends. If you are enrolled in Medicare or go to another employer that does not have a qualified high Deductible health plan, then you may continue to use your HSA to pay for Copayment and qualified medical expenses. You may not be eligible to contribute additional funds to your HSA and you should consult with your personal tax advisor.

77. What happens to my Health Savings Account if I pass away? If your spouse is the beneficiary of your HSA, then your HSA may be transferred to your Spouse's name and your Spouse may continue to use the HSA for qualified medical expenses tax free (as well as non-qualified expenses with income tax and penalty tax accessed). If the beneficiary is anyone other than your spouse, then the IRS requires that the account be cashed out. The beneficiary likely will be required to pay income tax on the cash value of the account but will not be subject to a penalty.

78. How do I designate a beneficiary for my Health Savings Account? Your bank will provide instructions for designating a beneficiary. If you open an HSA with OptumHealth Bank, then you may login to your HSA through www.optumhealthbank.com, select Forms and Information, and then fill out and submit the Beneficiary Designation form directly to OptumHealth Bank. Southwest Airlines will not accept beneficiary designation forms for HSAs.

79. What happens if I do not designate a beneficiary for my HSA prior to my death? If you do not specify a beneficiary and you are married, then your HSA will transfer to your spouse's name and become your spouse's account. If you are not married at the time of your death, then the funds will be cashed out and remitted to your estate subject to applicable taxation.

INVESTMENTS

80. Does the money in an HSA earn interest? Yes. Amounts on deposit in an HSA usually automatically earn interest and the interest is tax-exempt. For OptumHealth Bank, your interest rate will depend on the balance in your account. Contact your bank for additional information.

81. Can I invest money in my Health Savings Account? Yes. Once your account reaches a certain level typically referred to as "the investment threshold," then most banks allow you to invest the amounts on deposit in your HSA in your bank's specified line-up of investment options that likely include money market and mutual funds. Contact your bank for additional information.

82. Am I required to have a minimum balance in my HSA with OptumHealth Bank before I can begin making investments? Yes. Once your account reaches a designated value, known as the investment threshold (noted in question 86), then, if you choose, you may set up a separate investment account to invest a portion of your savings in mutual funds.

83. Will my default account with OptumHealth Bank allow me to make investments? The default account type is the OptumHealth eAccess. It does allow for investments after you set up a separate investment account. However, you will pay a higher Monthly investment fee with this account type.

84. What are the account types available at OptumHealth Bank? OptumHealth Bank has three account types available and has provided the following descriptions for each:

- *OptumHealth eAccess (the default)*—If you plan to use your account often for current medical expenses, this could be a good option for you. It has the lowest fee for carrying a smaller balance.

- *OptumHealth eSaver*—If you will be spending some now and would also like to invest for future medical expenses, this account could be a good option for you. It has competitive interest rates, moderate fees, and an option to invest for no additional fee.

- *OptumHealth eInvestor*—If your expenses are minimal now, but you want to grow your HSA for future medical expenses, this account allows you to start investing with a lower balance.

85. How do I change my account type with OptumHealth Bank? You may call OptumHealth Bank at (800) 791-9361 to change your HSA account type. You cannot change your account type online.

86. What maintenance and investment fees will I be required to pay? Most banks will charge a Monthly maintenance fee and a Monthly investment fee that will apply depending on your specific account type and account balance. Some banks charge additional fees. OptumHealth Bank does not charge trading fees, front-end charges, or redemption fees. If you open an account with OptumHealth Bank, Monthly fees will apply as described below. These fees will automatically be deducted by OptumHealth Bank each Month out of your HSA.

Account Type	OptumHealth eAccess (Default)	OptumHealth eSaver	OptumHealth eInvestor
Monthly Maintenance Fee	$1 if your average balance is less than $500	$3 if your average balance is less than $5,000	$3 if your average balance is less than $5,000
Monthly Investment Fee	$3 (balance of $2,000 required to invest funds)	$0 (balance of $2,000 required to invest funds)	$2.50 (balance of $500 required to invest funds)

87. Where can I find more specific information on the available investments in my HSA with OptumHealth Bank? You may go to www.optumhealthbank.com. Select "Investment Opportunities" under the "Using your Health Savings Account" drop-down menu. You may also call OptumHealth Bank at (800) 791-9361.

Qualified Expenses

88. Who determines what expenses are qualified medical expenses? The IRS provides guidance for determining qualified medical expenses for purposes of your HSA. IRS Publication 969 explains that qualified medical expenses are those that would generally qualify for the medical and dental expenses deduction as listed in IRS Publication 502. Go to www.irs.gov to view these publications. **It is your responsibility to ensure that you only use amounts on deposit in your HSA for qualified medical expenses.** If you need additional assistance to make this determination, then you should consult your personal tax advisor.

89. What are some examples of qualified medical expenses? Qualified medical expenses are determined by the IRS and *may* include the following: doctor's office visits; dental care, including orthodontia; eyeglasses, contacts, and LASIK surgery; prescription medications; acupuncture; chiropractic services; hearing aids (including batteries); long-term care medical expenses and insurance premiums; stop-smoking programs; physical therapy; psychiatric care; psychological counseling; and nursing home care.

90. May I use my Health Savings Account to pay for Dental and Vision expenses? You may use your HSA to cover eligible dental and vision expenses.

91. Is counseling from a registered dietician considered a qualified expense? It may be considered a qualified expense— but **only** with a Physician referral to treat a chronic condition.

92. May I use the money in the HSA to pay for voluntary cosmetic surgery? Generally, cosmetic surgery is not considered a qualified expense. However, in some circumstance, the IRS may permit cosmetic surgery but only if prescribed by a Physician as medically necessary.

93. May I use my Health Savings Account to cover health insurance premiums? Generally, you may not use your HSA to pay for health insurance premiums; however, there are some exceptions. You should consult the IRS publication or your personal tax advisor for additional assistance.

94. May I use my Health Savings Account to reimburse myself for expenses incurred before the account was opened? No. Your HSA must be open at the time the expense was incurred in order to reimburse yourself for that expense.

95. May I use my Health Savings Account to pay the cost of doctor's office visits when I am ill before I have reached my Health Savings Plan annual Deductible? Yes, you may use your HSA to pay for your doctor's visit. Some doctors may require you to pay upfront, but most will bill you later. Remember, if you use an In-Network Provider, then you are only required to pay the in-Network discounted amount and not the full amount charged.

96. Do I have to have the funds in my HSA before I can use them to pay a qualified medical expense? Yes, you must have sufficient funds available in your account at the time you pay for your medical expense. In addition, you may only use your HSA to pay for qualified medical expenses incurred *after* you open your account.

97. May I use my HSA whenever I want to pay for non-medical expenses? Yes. You may withdraw amounts from your HSA at any time, however, if you do not use the amounts for qualified medical expenses, then the amount dispersed may be subject to taxation and you may be subject to a penalty of twenty percent. This penalty may not apply if you are over age 65.

98. If I am enrolled under the Health Savings Plan but I do not enroll my children it the Health Savings Plan, may I use the money in my HSA to pay for my children's medical expenses like Copayment and Deductibles if they are enrolled for coverage through my Spouse's employer? Yes. The money in your HSA may be used to pay for or reimburse qualified medical expenses for any qualified dependent regardless of whether they are enrolled in the Southwest Health Savings Plan. Two things to remember: 1) You are subject to the Employee Only annual limit if you do not have other family members enrolled in the Health Savings Plan; and 2) expenses for dependents that are not enrolled in the Health Savings Plan will not be applied toward your Deductible in the Health Savings Plan even if the amounts are paid out of the HSA.

99. May I use the HSA for doctors that are Out-of-Network? Yes, you may use funds from your HSA to cover any qualified medical expenses—whether In-Network or Out-of-Network.

100. Is there a "credit card" that I can use to pay for my expense? You will receive a debit card, but not a credit card. Once your account is open, a Debit MasterCard will be issued that you may use to pay qualified medical expenses.

101. Do I have to use my Debit MasterCard to pay for my qualified medical expenses? No, you may use the online bill pay or you may order checks from OptumHealth Bank for an additional fee.

102. Must I use the money in the account to pay for my medical expenses in the Year I deposit the funds? No, you may use the money in your account in future Years including during retirement.

103. Is there a minimum reimbursement amount for the HSA account? No, there is no minimum amount.

104. If I am in another country, may I use my HSA to pay for expenses? Yes, you may use your HSA to cover qualified medical expenses incurred in any country; however, it is likely that you will have to pay the amount upfront and then reimburse yourself.

105. What are my options if I use my HSA to pay for an expense that later is found not to be a qualified medical expense? You may redeposit those funds that have been used in error for non-qualified expenses by completing the withdrawal correction process at your bank before the time at which your tax return is due (generally, April 15 of the following Year). If you opened an account with OptumHealth Bank, then you may obtain the form at www.optumhealthbank.com. If you do not complete the withdrawal correction process, then the amounts withdrawn will be subject to applicable income taxes and a twenty percent penalty.

106. Do I have to keep receipts for my qualified expenses? The IRS recommends that you retain all receipts to document your qualified medical expenses in the event you are subject to an IRS audit.

107. May I use my HSA to reimburse myself for qualified medical expenses incurred in a prior Year? Yes. You may use your HSA to pay for medical expenses incurred in a prior Year but only if your **Health Savings Account was open at the time the expense was incurred and you can substantiate the expenses.**

108. May I use amounts in my Health Savings Account to pay for medical expenses for my adult child who I enrolled under the Health Savings Plan but who is no longer a tax dependent? No. If you enroll an adult child who is not a tax dependent under the Health Savings Plan option, although your adult child is eligible for benefits coverage, you may not use amounts deposited in your HSA to pay for or reimburse yourself for medical expenses attributable to your adult child. Amounts in an HSA may only be used to pay for qualified medical expenses of qualified federal income tax dependents. Your adult child may be eligible to open his or her own HSA.

109. May I use funds in my HSA to pay for or reimburse expenses for my Committed Partner? Maybe. The IRS requires that amounts in an HSA only be used to pay for qualified medical expenses for qualified tax dependents. It is your responsibility to ensure that amounts are only used to pay for expenses for qualified dependents. The Plan does not determine whether your Committed Partner is a qualified tax dependent. You should consult your personal tax advisor if you need additional assistance making this determination.

TAX FILING REQUIREMENTS

110. Do I report this account on my taxes? Maybe. You may need to include additional tax reports with your annual tax filing, such as the following:

- **IRS Form 1099-SA** is provided to you by your bank and lists the total distributions that were made from your HSA. You will receive a separate 1099-SA for each type of distribution you had in that tax Year. The five types of distributions are: normal, excess contribution removal, death, disability and prohibited transaction. If you did not have distributions during the tax Year, then you will not receive a 1099.
- **IRS Form 5498-SA** is provided to you by your bank and documents the contributions that you made to your HSA during the tax Year. This form is usually distributed in May because account holders may make contributions to an HSA for a tax Year until April 15 of the following Year.
- **IRS Form 8889** is a form that you may attach to your IRS 1040 Form to report contributions.

111. Will my Form W-2 issued from Southwest Airlines include my HSA contributions that were payroll deducted? Yes. If you open an account with OptumHealth Bank and elect to make your contributions through payroll deduction, then your Southwest Form W-2 will have a "W" in Box 12 with the dollar amount contributed to your HSA on a pre-tax basis.

112. Are my HSA contributions also exempt from state income tax? Maybe. HSA contributions are not taxed by most states, but they are taxed in some states including but not necessarily limited to **Alabama, California** and **New Jersey**. Please consult your tax advisor or state department of revenue for more information.

113. Who do I contact for additional help or questions regarding my HSA or tax requirements? You should consult with your personal tax advisor if you have additional questions regarding your HSA or tax filing requirements.

END OF SECTION

DENTAL PROGRAM

GENERAL INFORMATION: You may go to any Dentist or Physician, however, benefits under the Dental Program depend on whether You choose BenefitsPlus or the Regular Plan and are paid according to the schedule below:

	BENEFITSPLUS		REGULAR PLAN
	BASIC DENTAL	OPTIONAL DENTAL	DENTAL
PREVENTIVE TREATMENT (no Deductible)	100%	100%	100%
ANNUAL DEDUCTIBLE	$50 Per Person	$50 Per Person	$50 Per Person
DENTAL SEALANTS (for children under age 15) (no Deductible)	Not Covered	100% of Covered Charges for one application per tooth every five Years for the first and second molars up to age 15	Not Covered
BASIC TREATMENT (after Deductible)	75% of Covered Charges	80% of Covered Charges	75% of Covered Charges
MAJOR TREATMENT (after Deductible)	60% of Covered Charges	80% of Covered Charges	60% of Covered Charges
ANNUAL MAXIMUM BENEFIT	$1,500 Per Person	$2,000 Per Person	$1,000 Per Person
ORTHODONTIA (after Deductible)	60% of Covered Charges up to a Lifetime Maximum Benefit Payment of $1,500 per person	80% of Covered Charges up to a Lifetime Maximum Benefit Payment of $2,000 per person	60% of Covered Charges, up to a Lifetime Maximum Benefit Payment of $1,000 per person
SPECIAL SERVICES[1] (no Deductible)	80% of Covered Charges per person	80% of Covered Charges per person	80% of Covered Charges per person

[1]Benefits for Special Services will not be applied to Your Annual Maximum Benefit Payment and are not subject to the Dental Program Deductible.

DENTAL DISCOUNT NETWORK: A dental discount network is part of the Dental Program and In-Network Providers offer a discount off certain covered dental services resulting in savings to You and Southwest. Individuals are not required to use In-Network Providers; however, if you choose an Out-of-Network Provider then the Plan will only pay the appropriate percentage of the Maximum Plan Allowance amount for Covered Charges. To find out if Your dental Provider is part of the dental discount network or to find a network Dentist, contact the Claims Administrator for the Dental Program. If you would like to locate an In-Network Provider, log onto www.deltadentalins.com/southwest or call (866) 204-5502.

DECLINING DENTAL COVERAGE: Under BenefitsPlus, You may decline Dental coverage. If You decline Dental coverage, then You will receive extra pay and You, Your Family Member, Your Committed Partner, and Your Committed Partner's children will not be eligible to receive any Benefits under the Dental Programs.

DEDUCTIBLE: The Deductible is the amount of Covered Charges You pay each Calendar Year before Benefits are payable from Your Dental Program. Your Deductible starts over each January 1 and applies separately to each Covered Individual. Covered Charges which are incurred during October, November, and December and which are applied to the Deductible, will also be applied to the Deductible for the next Calendar Year. Some charges may not apply to the Deductible, including charges that the Plan does not cover or charges that exceed the Allowable Amount.

ANNUAL MAXIMUM BENEFIT PAYMENT: The annual maximum benefit payment that You may receive for Covered Charges incurred by any Covered Individual depends on the dental options that You selected. The maximums start over each January 1 and there is no carryover from Year to Year. When a Covered Individual reaches the annual maximum benefit payment, no additional Benefit payments will be made for the remainder of the Calendar Year. Any Benefit payments made at any time under the Covered Individual's Dental Program or under any other Dental Program sponsored by Southwest will be used in determining the annual maximum benefit payment. If a Covered Individual changes status from Primary Covered Individual (Employee) to Covered Family Member or from Covered Family Member to Primary Individual (Employee), Benefits paid in the previous status will be used in determining the annual maximum benefit payment.

LIFETIME MAXIMUM FOR ORTHODONTIA: A separate lifetime maximum applies to orthodontia treatment as shown in the Covered Dental Charges. When a Covered Individual reaches the lifetime maximum benefit payment for orthodontia treatment, no additional Benefit payments will ever be made. Any Benefit payments made at any time under the Covered Individual's Dental Program or any other Dental plan sponsored by Southwest will be used in determining the lifetime maximum benefit payment for orthodontia treatment. If a Covered Individual changes status from Primary Covered Individual (Employee) to Covered Family Member or from Dependent to Primary Covered Individual (Employee), Benefits paid in the previous status will be used in determining the lifetime maximum benefit payment for orthodontia treatment.

LIMITATIONS: If a Covered Individual has covered dental charges from more than one Dentist or Physician for the same treatment, material, or supplies, then payment by the Plan will be determined on the basis that only one Dentist or Physician furnished the treatment, materials, or supplies.

- If a Covered Individual incurs charges for a particular Course of Treatment, including treatment already in progress for a dental problem or disease or orthodontia, and the coverage for the Covered Individual changes for a subsequent Plan Year, then, to the extent such coverage (i) increases, the Covered Individual will be covered at the coverage level in place when the Course of Treatment was initiated, or (ii) decreases, the Covered Individual will be covered for such treatment at the coverage level selected for the subsequent Plan Year.

ALTERNATE BENEFIT: Recognizing that many dental problems can be solved in more than one way and subject to the limitations of the Plan, the Plan will pay an amount equal to the cost for that generally-accepted treatment which will provide adequate dental care at the lowest cost to You. Nationally established standards for the dental profession will be followed when determining the liability of the Plan. If You receive the most expensive Course of Treatment, the Plan may only pay the charges applicable of a less expensive treatment (which would adequately restore the mouth to normal form and function). This payment may be applied toward a more expensive Course of Treatment.

PRETREATMENT ESTIMATE OF BENEFITS: Before treatment, always ask the Dentist to fully explain any suggested treatment including how much the treatment will cost. It is recommended that You get a pretreatment estimate of Benefits before the treatment starts to help You understand the costs before the services are performed and whether the charges are covered by the Plan.

Steps You or the Dentist Must Follow for a Pretreatment Estimate of Benefits:

1. Submit a description of the Course of Treatment and costs (especially those that are expected to exceed $300) to the Claims Administrator before the treatment is provided to determine which charges the Dental Program covers.
2. The Claims Administrator may require the Covered Individual to submit to an oral examination at Your own expense and to furnish existing diagnostic and evaluation material.
3. The Claims Administrator will provide to You an estimate of Benefits payable for the planned Course of Treatment.

COVERED DENTAL CHARGES UNDER THE MEDICAL PROGRAM: Some charges for dental treatment are listed as covered charges under the Medical Program and these charges should be submitted to the Medical Program Claims Administrator. Charges covered by the Medical Program are not covered under the Dental Program. Dental charges covered by the Medical Program include: (i) repair or replacement of natural teeth as a result of an accidental bodily injury; (ii) the treatment of a malignant condition of the gums or supporting tissue of the teeth and the treatment to restore any lost function as a result of the malignant condition; and (iii) Medically Necessary hospital charges for the treatment of a dental condition.

	COVERED CHARGES
PREVENTIVE TREATMENT	• Initial, periodic or emergency oral examinations and routine teeth cleaning (prophylaxis) up to two times each Calendar Year • Topical fluoride application up to two times each Calendar Year • Dental x-rays, including: - Full-mouth x-rays once every 36 consecutive Months - Supplementary bitewing x-rays up to two times each Calendar Year - Any other dental x-rays required in connection with a diagnosis of a specific condition requiring dental treatment • Space maintainers for children up to age 19 • BenefitsPlus Optional Dental ONLY: Dental sealants applied to the first and second molars for children Younger than age 15, one application per tooth every five Years
BASIC TREATMENT	• Extractions and oral surgery • Restorative-type fillings (amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth) • Nitrous oxide • General and local anesthetic and I.V. sedation when administered for oral surgery • Treatment of periodontal and other diseases of the gums and tissues supporting the teeth which includes periodontal cleanings and scaling and root planning • Inlays, onlays or gold fillings • Endodontic treatment, including root canal • Injection of antibiotic drug • Repair or recementing of crowns, inlays, onlays, implants, bridgework, or dentures • Relining or rebasing of dentures more than six Months after the installation of an initial or replacement denture, but not more than once every 36 consecutive Months • Emergency Palliative treatment • Removal of benign tumors or tissue in the mouth
ORTHODONTIA TREATMENT	• Charges of a Dentist for treatment, materials and supplies furnished to a Covered Individual in connection with Orthodontia treatment • Charges will be considered incurred, subject to Dental Program conditions, as follows: (i) 25% of the total case fee will be considered as being incurred on the date the initial active appliance is placed, and (ii) the remainder of the total case fee will be divided by the number of Months for the total treatment plan. The resulting portion will be considered to be incurred on a Monthly basis until the Lifetime Maximum Benefit is paid, treatment is completed, or eligibility ends.
SPECIAL SERVICES	• Services to remove impacted wisdom teeth • Gingivectomy • Alveolectomy

	Covered Charges

Major Treatment	• Crowns
	• Implants
	• Initial installation of (i) fixed bridgework including inlays and crowns as abutments and (ii) partial or full removable dentures (including precision attachments and any adjustments during the six Month period following installation) to replace: one or more extracted natural teeth, or congenitally missing teeth for a Covered Individual age 23 and under (Optional Plan under BenefitsPlus only).
	• Bone Grafts are covered once per lifetime per tooth.
	• If the Prosthesis Replacement Rule is met, replacement of (i) existing bridgework by new bridgework or implant, or the addition of teeth on existing bridgework or (ii) existing partial or full removable denture by a new denture or implant, or the addition of teeth to a partial removable denture.
	The Prosthesis Replacement Rule provides that replacements or additions to existing dentures, bridgework, or implants will be covered only if the Claims Administrator receives satisfactory evidence that one of the following applies.
	• The replacement or addition of teeth is required to replace:
	  • One or more teeth extracted after the existing denture, bridgework or implant was installed, or
	  • Congenitally missing teeth for a Covered Individual age 23 and under (Optional Plan under BenefitsPlus only).
	• The existing denture, bridgework, or implant cannot be made serviceable and was installed at least five Years prior to its replacement.
	• The existing denture and immediate temporary denture cannot be made permanent and replacement by a permanent denture takes place within 12 Months from the date of initial installation of the immediate temporary denture. (Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework or implants, the charge for that bridgework or implant will be included as a covered dental expense.)
	
	After a Covered Individual's coverage ends, the Plan will cover charges for the installation of a dental appliance, a crown, an implant, a bridge or gold restoration furnished within 90 days of the date such coverage ends if all of the following conditions are met: (i) an impression for the appliance is taken before the date coverage ends; (ii) the tooth was prepared for the crown, bridge, implant or gold restoration before the date coverage ends; and (iii) the Covered Individual is not entitled to payment for the installation under any other insurance plan of any type or source.

Charges NOT Covered Under the Dental Program

Charges NOT Covered under the Dental Program
• Charges not specifically stated as a Covered Charge
• Any treatment, including materials and supplies, which were incurred prior to being covered under Your Dental Program or after coverage under Your Dental Program ends, except under Major Treatment as specifically provided above certain charges incurred after Your coverage ends will be considered a Covered Expense
• Treatment, materials or supplies furnished by anyone other than a Dentist or Physician except, if working under the direct supervision of a Dentist or Physician: (i) Student Dentists who perform services at a dental college as part of their training and education, or (ii) Licensed dental hygienists for scaling or cleaning of teeth and topical application of fluoride.
• Treatment, materials or supplies for Cosmetic Purposes, including, but not limited to, personalization or characterization of dentures
• Replacement of lost, missing or stolen prosthetic or orthodontic appliances
• Dentures, crowns, inlays, onlays, bridgework or other treatment, materials or supplies provided to alter vertical dimension or alter occlusion
• Which, in the absence of this coverage, You are not legally obligated to pay
• Treatment, materials or supplies for which benefits are provided or paid under any law of a government, except when payment is required by law
• Prosthetic appliances (including, but not limited to, bridges, implants and crowns) and the fitting of them if they were ordered while You were not covered by Your Dental Program, or if they were ordered while You were covered but delivered or installed while You were not covered by Your Dental Program, except as specifically provided otherwise under Major Treatment above
• Your failure to keep a scheduled appointment with Your Dentist or Physician
• Completing claim forms and forms required by Your Dental Program for processing of claims
• Periodontal splinting and appliances
• Treatments, material or supplies which are Experimental, Investigational or Unproven in nature
• Night and bite guards
• Treatments, material or supplies which are not Medically Necessary
• Consultations and office visits
• Infection control including, but not limited to, gloves, masks and sterilization
• Any accidental bodily injury which arises out of or in the course of any employment with any employer or for which the Covered Individual is entitled to benefits or receives a settlement under any Workers' Compensation law or Occupational Disease law
• Any illness for which the Covered Individual is entitled to benefits under any Worker's Compensation or Occupational Disease law, or receives any settlement from a Workers' Compensation carrier
• Losses due to war or act of war, whether declared or undeclared, or from engaging in the commission of a crime, or participation in a riot
• Excess of the Allowable Amount charges for services and materials
• Services performed by a person who usually lives in the same household as the Covered Individual, or who is a member of his/her immediate family or the family of his/her Spouse or Committed Partner or Committed Partner's children
• Services performed by a person who is also an Employee of Southwest or who is also a Covered Individual under the Dental Programs
• Charges covered under the Southwest Medical Program or any other Southwest benefit plan
• Any service that is not necessary or is not normally performed for proper dental care of the condition, or any service that is not approved by the attending Dentist or Physician
• Services or supplies that do not meet accepted standards of dental practice
• Oral hygiene, dietary instruction, or plaque control programs
• Charges that would not have been made if no coverage existed, except where required by law

End of Section

VISION PROGRAM

GENERAL INFORMATION: The Vision Program is an insured program (not self-insured by Southwest). The benefits paid under the Vision Program depend on whether You choose BenefitsPlus or the Regular Plan and whether You select an In-Network Provider or an Out-of-Network Provider as shown in the schedule below. **There is no assurance that amounts paid according to the schedule will cover the entire cost of the examination, frame and lenses, or contact lenses.** If You have any **questions or complaints** about Your Vision Program benefits, You should contact the Insurance Carrier.

- The certificate from the insurance Provider is available on SWALife. To the extent there are any discrepancies between this SPD and the applicable insurance certificate for this Program, the insurance certificate shall govern.

- You have access to an expansive network of doctors and vision care centers including popular convenient retail location (e.g., LensCrafters, Sears, Target Optical, Pearl Vision, JCPenney Optical). For a comprehensive summary of vision benefits And In-Network Providers go to www.eyemedvisioncare.com/swa or call (855) 219-4451 Once you find an In-Network Provider, you should inform the In-Network Provider that EyeMed vision Care is your insurance Provider to access your benefits.

- If You use an Out-of-Network Provider, then You must pay the Out-of-Network Provider the full cost at the time the covered service is provided and file a claim with the Claims Administrator. The Claims Administrator will reimburse You for the Out-of-Network Provider benefits up to the maximum dollar amount allowed.

- Vision Program benefits are covered only when and to the extent they are deemed **Medically Necessary** for the proper treatment of a condition. This will be decided by the Provider responsible for the care subject to the Insurance Carrier's review. Objections to a decision should be directed to the Insurance Carrier.

- If You have an **emergency** and You cannot receive care from an In-Network Provider, You will be reimbursed according to the Out-of-Network Provider reimbursement schedule. If You have an emergency and cannot find an In-Network Provider in Your area, contact the Insurance Carrier for assistance.

- **Copayments** (Copayments) must be paid to the Provider on the date services are rendered or as otherwise agreed to by the Provider.

Vision Care Services BenefitsPlus	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilations as Necessary	$10 Copayment	Up to $40
Contact Lens Fit and Follow-Up		
Standard Contact Lens	Up to $40	N/A
Premium Contact Lens	10% off retail	N/A
Retinal Imaging	Up to $39	N/A
Frames	$0 Copayment, $130 Allowance; 20% off balance over $130	Up to $45
Standard Plastic Lenses		
Single Vision, Bifocal, Trifocal	$10 Copayment	Up to $40, $60, $80
Standard Progressive Lens	$75	Up to $60
Premium Progressive Lens	$101—$113	N/A
Other Premium Progressive Lens	$75, 80% of charge less $120 Allowance	Up to $60
Lenticular	$10 Copayment	Up to $80
Lens Options		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	Up to $8
Standard Polycarbonate	$0[1]	Up to $20
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating	$57-$68	N/A
Other Premium Anti-Reflective	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lenses (materials only)		
Conventional	$0 Copayment, $150 Allowance; 15% off balance over $150	Up to $150
Disposable	$0 Copayment, $150 Allowance; plus balance over $150	Up to $150
Medically Necessary	$0 Copayment; Paid in full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
For Lasik Providers, call 1-877-5LASER6		
Frequency		
Examination	Once every 12 Months	
Lenses or Contact Lenses	Once every 12 Months	
Frame	Once every 24 Months	

[1]For the Regular Plan, In-Network the member cost for standard polycarbonate is $40.

- A **complimentary eye evaluation and consultation to determine candidacy for laser eye surgery** will be given to each Covered Family Member and, if approved as a candidate, discounted refractive eye surgery procedures from a laser-approved In-Network Provider are available.

- Additional **In-Network** Discounts and Features:
  - 40% discount off eyeglass purchases once the funded benefit has been used
  - 15% discount off conventional contact lenses
  - 20% off non-prescription sunglasses (all the time)
  - 20% off other purchases outside of benefit. (Example: lens towelettes)

LOW VISION BENEFIT: A Low Vision reimbursement benefit is available to Covered Family Members who have severe visual problems that cannot be corrected with regular lenses. The benefit is available where a Provider has determined a need for and has prescribed the service. The total amount paid under this benefit will be limited to $1,000.00 every two Calendar Years. The Insurance Carrier will reimburse the cost of covered services directly to You as follows.

	In-Network Provider	Out-of-Network Provider
Supplementary Testing • Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.	100% of covered charges	75% of covered charges
Supplemental Care • Subsequent low vision therapy if prescribed	75% of covered charges	75% of covered charges
Maximum Benefits	$1,000 every two Years	

HOW OFTEN YOU ARE ELIGIBLE TO RECEIVE COVERAGE FOR SERVICES/MATERIALS: How often You are eligible to receive coverage for an examination, a frame and lenses, or contact lenses depends on (i) when You last received coverage for services/materials under the Vision Program and (ii) whether or not You were continuously covered under the Vision Program. Generally, You may begin to receive coverage for services/materials each January 1 following the Year that You last received coverage for services/materials. In any Calendar Year, You may not receive coverage for both a frame and lenses and contact lenses.

Examination	Covered once each Calendar Year.
Lenses	Covered once each Calendar Year.
Frames	Covered once every other Calendar Year.
Contact Lenses	Covered once each Calendar Year and includes the contact lenses and examination (fitting and evaluation). Note: If You choose contact lenses, this benefit will replace the benefit for a frame and lenses for the period listed above.

ELIGIBLE CHARGES: The Vision Program is designed to cover visual needs rather than cosmetic eyewear and pays only for specific services and eyewear. Your eligibility to receive services/materials is determined by the Year You last received that service/material under the Vision Program.

	COVERED CHARGES
VISION EXAM	You are eligible once each Calendar Year for a vision survey examination of the condition of the eyes and principal vision functions, to include: • A case history, including chief complaint and/or reason for examination, patient medical/eye history, current medications, etc. • Recording of monocular and binocular visual acuity, far and near, with and without present correction (20/20, 20/40, etc.) • Cover test at 20 feet and 16 inches (checks eye alignment) • Ocular motility including versions (how well eyes track), near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception • Pupil responses (neurological integrity) • External exam • Internal exam • Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses • Subjective refraction – to determine lens power of corrective lenses • Phorometry/Binocular testing – far and near: how well eyes work as a team

	▪ Tests of accommodation and/or near point refraction: how well Covered Person sees at near point (reading, etc.) ▪ Tonometry, when indicated: test pressure in eye (glaucoma check) ▪ Ophthalmoscopic examination of the internal eye ▪ Confrontation visual fields ▪ Biomicroscopy ▪ Color vision testing ▪ Diagnosis/prognosis ▪ Specific recommendations
LENSES	You are eligible once each Calendar Year for one pair of lenses including prescription, ordering, proper fitting and adjustment. Covered lenses include: ▪ Single vision ▪ Bifocal – lined ▪ Trifocal – lined ▪ Lenticular vision ▪ Polycarbonate lenses covered in full at In-Network Providers (BenefitsPlus Only) If You choose lenses and/or frames that are more expensive than the basic and allowable expense, You will have to pay the additional cost.
FRAME	You are eligible once every other Calendar Year for one frame. The Vision Program has an allowance of $130 toward any frame purchased from an In-Network retail optical Provider. If you choose a frame that exceeds your allowance you will pay the difference between the cost of the frame and the allowance, less a 20% discount.
CONTACT LENSES	You are eligible once each Calendar Year for one pair of contact lenses, including contact lens fitting and adjustment. **If You use an In-Network Provider,** You will receive a $150.00 allowance ($105.00 under the Regular Plan) that will be applied toward the evaluation, fitting and purchase of contact lenses once every Calendar Year. In order to receive the full allowance, You must receive Your exam, fitting, and evaluation at the same In-Network Provider. **If You use an Out-of-Network Provider,** You may select contact lenses and the Insurance Carrier will pay a maximum benefit of $150.00 ($100.00 under the Regular Plan) for elective contact lenses and $210.00 for necessary contact lenses. If Your contact lenses are necessary, the Provider must submit a request to the Insurance Carrier for approval prior to dispensing the contact lenses. To refill Your contact lenses online for added savings go to www.optumhealthvision.com>login>access and select Mail Order cContacts which will redirect You to the Vision Direct website. Enter the coupon code as indicated to save 10% off Your order. The purchase of contact lenses is in lieu of lenses. If You receive contact lenses from the Vision Program, no other lens expense of any type will be covered in that Calendar Year.

CHARGES NOT COVERED UNDER THE VISION PROGRAM

No benefits will be paid for services or material connected with or charges arising from:

- orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
- aniseikonic lenses;
- medical and/or surgical treatment of the eye, eyes or supporting structures;
- safety eyewear;
- services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- plano (non-prescription) lenses;
- non-prescription sunglasses;
- two pair of glasses in lieu of bifocals;
- services or materials provided by any other group benefit plan providing vision care;
- services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days from the date of such order; or
- lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.
- Non-prescription items
- Services or materials which the patient, without cost, obtains from any governmental organization or program
- Services and materials which are not specifically covered by the Policy
- Cosmetic extras including, but not limited to, oversized lenses, blended lenses, coated lenses, tinted lenses, photochromatic lenses, frames costing more than the frame allowance, progressive multifocal lenses, laminating of the lens or lenses, cosmetic lenses, optional cosmetic processes, and UV (ultraviolet) protected lenses
- Replacement or repair of lenses and/or frames which have been lost or broken
- Medical or surgical treatment for eye disease, which requires the services of a Physician
- Any eye examination required by an employer as a condition of employment by virtue of a labor agreementor a government body or agency
- Diagnostic tests that are delivered in other than a Physician's office or health care facility including self-administered home diagnostic tests

REQUESTING TO USE YOUR VISION COVERAGE: The Vision Program requires that You follow certain steps to ensure You receive the maximum benefit from Your Vision coverage.

In-Network Provider	Out-of-Network Provider
1. Locate an In-Network Provider by visiting the Insurance Carrier's website or by calling the Insurance Carrier. They can help You locate an In-Network Provider and answer any questions You may have. 2. Call and make an appointment with the In-Network Provider. 3. The In-Network Provider will contact the Insurance Carrier to verify Your eligibility and Vision Program coverage and the services You are eligible to receive. The In-Network Provider will notify You if You are not eligible for services. 4. The In-Network Provider will ask You to pay the Copayment or, if applicable, any amount above the Vision Program benefit.	1. Pay the Provider in full and obtain an itemized copy of the bill if You receive services from a Non- In-Network Provider. The itemized bill must include: - Your name - Your Social Security Number - Your employer's name - Patient's name, birthdate and relationship to You - A separate description of charges for the eye examination and materials, including lens type. 2. Send a copy of the itemized bill to the Insurance Carrier with a completed claim form. Claim forms are available online or by calling customer service. 3. The Insurance Carrier will reimburse You for services received from an Out-of-Network Provider according to the reimbursement schedule. Your reimbursement may not cover the entire cost You incur from the Out-of-Network Provider.

NOTICE OF CLAIMS: You must give notice of claim as determined by the Insurance Carrier to the Insurance Carrier within 30 days of the date of service. The notice must be given with sufficient information to identify the patient. Failure to file such notice within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time; however, the notice must be given as soon as reasonably possible.

PAYMENT OF CLAIMS:

- **In-Network Providers** will accept Your Copayment for covered services and materials at the time of appointment. In-Network Providers will not bill You for covered services in excess of Your Copayment.

- Reimbursement for services or materials received from **Out-of-Network Providers** will be made directly to You. All benefits will be paid within 60 days after the Insurance Carrier receives satisfactory proof of loss.
If a claim is partially paid, You will receive a written notice explaining how the claim was processed and giving notice of Your appeal rights as to the unpaid portion. If a claim is denied in whole, a written Notice of Benefit Determination will be sent to You explaining Your appeal rights.

APPEALS FOR VISION PROGRAM: Claims Administrator of the Vision Program in accordance with the Claims Procedures set forth in Section 1 of this SPD. Claims and appeals under the Vision Program are subject to those portions of the claims procedures that apply to group health plans.

DEADLINES FOR FILING A LAWSUIT: YOU CANNOT BRING ANY LEGAL ACTION AGAINST SOUTHWEST OR THE CLAIMS ADMINISTRATOR OF THE VISION PROGRAM TO CHALLENGE AN ADVERSE CLAIM DETERMINATION UNDER THE VISION PROGRAM UNLESS YOU FIRST COMPLETE ALL THE STEPS IN THE BENEFIT CLAIMS APPEAL PROCESS DESCRIBED IN SECTION 1 OF THIS SPD. AFTER COMPLETING THAT PROCESS, IF YOU WANT TO BRING A LEGAL ACTION AGAINST SOUTHWEST OR THE CLAIMS ADMINISTRATOR, YOU MUST DO SO WITHIN THREE YEARS OF THE EARLIER OF THE DATE YOUR EMPLOYMENT ENDS OR THE DATE YOU ARE NOTIFIED OF THE CLAIM ADMINISTRATOR'S FINAL DECISION ON APPEAL; OTHERWISE, YOU LOSE ANY RIGHTS TO BRING SUCH AN ACTION AGAINST SOUTHWEST OR THE CLAIMS ADMINISTRATOR.

END OF SECTION

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PROGRAM

GENERAL INFORMATION: Southwest offers both term Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance Program is an insured product that offers coverage to help protect You and Your family from financial hardships if You or a Covered Family Member dies or if You or a Covered Family Member suffer an accidental death or injury. Your options, the coverage, and the requirements for this Program vary depending on whether You are enrolled in the BenefitsPlus or the Regular Plan under the Medical Program.

The certificate from the insurance Provider is available on SWALife. To the extent there are any discrepancies between this SPD and the applicable insurance certificate for this Program, the insurance certificate shall govern.

- **Optional Insurance for Committed Partner's and their children is only available in BenefitsPlus.**

- **Beneficiary Designation:** Life Insurance Beneficiary Designation must be completed through the MetLife web site at www.metlife.com/mybenefits. Effective June 15, 2013, paper life insurance designation forms will not be accepted by the Health & Wellness Team except for Committed Partner designations as described immediately below.

- If you have a Committed Partner enrolled in the Plan, You are required to file a paper beneficiary form with the Health & Wellness Team that designates your Committed Partner as the primary beneficiary for at least 50% of your benefits under the Life Insurance Program. If at any time you remove your Committed Partner from coverage under the Plan, you will then be required to go to www.metlife.com/mybenefits to complete an updated beneficiary designation online. You may request a paper form by contacting the Health & Wellness Team.

PREMIUMS: Basic Life Insurance is provided to You at no cost in both BenefitsPlus and the Regular Plan.

- In the Regular Plan, if You have Basic Life coverage, then You automatically receive an equal amount of Basic AD&D and, if You elect Optional Life, then You automatically receive an equal amount of Optional AD&D. This automatic AD&D coverage under the Regular Plan is provided at no cost to You.

- If You choose to purchase additional life insurance and/or accidental death and dismemberment insurance for You and/or an Family Member then You will be responsible for paying premiums for this additional coverage. Premiums for Your Optional Life and Spouse/Committed Partner Life will be based on Your age and Your Spouse/Committed Partner's age as of December 31 of the current Calendar Year or December 31 following Your date of hire.

COVERAGE: Your Life and AD&D Coverage Amounts are determined by Your base annual pay currently in effect. Your Coverage Amount will change as of the date of Your pay or job classification change provided You are Actively at Work on that date.

- The Insurance Carrier limits Optional Life Insurance, Spouse Life Insurance, and Accidental Death and Dismemberment coverage for individuals over age 70; therefore, effective January 1 of the Year you or your Spouse/Committed Partner will reach age 70, as applicable, your coverage amount for the applicable program will be reduced by 50% (regardless of whether your election rolls over or you affirmatively elect a coverage level during annual enrollment) and your premiums will be adjusted accordingly. Amounts reduced are rounded to the next multiple of $1,000, if not already an even multiple.

- Your **base annual pay** is determined by Your job classification. Overtime, per diem, shift differential, bonuses, commissions or any other compensation in addition to Your regular earnings are not included in Base Annual Pay.

	BASE ANNUAL PAY
Flight Attendants	Your Base Annual Pay equals Your Base Monthly Pay times 12 Months. Your Base Monthly Pay equals Your individual rate of pay per trip times 94 trips.
Pilots	Your Base Annual Pay equals Your Base Monthly Pay times 12 Months. Your base Monthly pay equals Your individual rate of pay per trip times 95 trips.
Hourly Fulltime Employees	Your Base Annual Pay equals Your hourly rate of pay times 2,080.
Other Fulltime Employees	Your Base Annual Pay equals Your Monthly rate of pay times 12.
Hourly Parttime Employees	Your Base Annual Pay equals Your hourly rate of pay times 1,040.

BENEFITSPLUS LIFE AND AD&D BENEFITS SUMMARY:

	BASIC LIFE	OPTIONAL LIFE	AD&D (EMPLOYEE ONLY OR EMPLOYEE +FAMILY)	SPOUSE OR COMMITTED PARTNER	CHILD LIFE
COVERAGE LEVELS ARE BASE ANNUAL PAY (ROUNDED TO NEXT HIGHER $1,000) OR A FLAT DOLLAR AMOUNT	1 Times	1 Times 2 Times 3 Times 4 Times 5 Times 6 Times 7 Times 8 Times 9 Times 10 Times	1 Times 2 Times 3 Times 4 Times 5 Times 6 Times 7 Times 8 Times 9 Times 10 Times	$10,000 $20,000 $30,000 $50,000 $100,000 $150,000 $250,000	$10,000 $20,000
ELIGIBILITY[1] Your coverage will begin on the later of the dates indicated.	All Eligible Employees ▪ Date You become Eligible.	All Eligible Employees ▪ The Date You become eligible, if elected on or before that date. ▪ Date elected if elected within 30 days after You become eligible (for that amount not subject to evidence of insurability). ▪ Date carrier approves Your evidence of insurability (for that amount subject to evidence of insurability).	All Eligible Employees ▪ Date You become eligible, if elected on or before that date. ▪ Date elected if elected within 30 days after You become eligible.	Eligible Spouse or Committed Partner ▪ Date You become eligible. ▪ Date Your dependent becomes eligible, if elected on or before that date. ▪ Date elected for dependent insurance, if elected within 30 days after Your dependent becomes eligible (for that amount not subject to evidence of insurability). ▪ Date carrier approves Your evidence of insurability (for that amount subject to evidence of insurability).	Eligible children or Eligible Committed Partner children ▪ From live birth for 30 days at lowest level. If elected within 30 days of birth, the requested level of coverage will apply as of date of birth.
MAXIMUM	$50,000	$3 Million (combined with Basic Life)	$2 Million	No greater than the aggregate Basic and Optional Life an Employee is eligible to elect.	No greater than the aggregate Basic and Optional Life an Employee is eligible to elect.

[1]You may be required to provide Statement of Health to determine Your eligibility when You enroll.

REGULAR PLAN LIFE AND AD&D BENEFITS SUMMARY:

	BASIC LIFE/AD&D	OPTIONAL LIFE/AD&D	SPOUSE	CHILD LIFE
COVERAGE FOR ALL ELIGIBLE PILOTS AND CORPORATE OFFICERS	$50,000	$50,000 $100,000 $150,000	$10,000	$1,000 each child less than six Months $5,000 each child six Months and older
COVERAGE FOR ALL OTHER ELIGIBLE EMPLOYEES WITH BASE ANNUAL PAY			$10,000	$1,000 each child less than six Months $5,000 each child six Months and older
$30,000 and over	$50,000	$50,000		
$20,000 but less than $30,000	$30,000	$30,000		
$15,000 but less than $20,000	$20,000	$20,000		
$10,000 but less than $15,000	$15,000	$15,000		
Less than $10,000	$10,000	$10,000		

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BENEFITSPLUS—SUICIDE EXCLUSION: If You or a Covered Family Member commits suicide or dies as a result of any other intentionally self-inflicted injury, while sane or insane, benefits for Optional Life and/or Spouse/Committed Partner and/or Child Life/Committed Partner Child Life will not be payable unless You or Your Covered Family Member has been continuously covered for at least two Years. If You or Your Covered Family Member commits suicide within two Years after the effective date of a requested increase in coverage, the Plan will limit its benefit payment for the increased portion to a payment equal to the Monthly deductions made for such increase. An increase in Your Life Insurance due to a salary or other non-elective change will not be subject to the suicide exclusion.

BENEFITSPLUS—REPATRIATION BENEFIT: If You die more than 200 miles from Your primary place of residence, a repatriation benefit will be paid to the person who incurs the transportation charges or for charges incurred to transport Your body to a mortuary near Your primary place of residence not to exceed $5,000 or 10% of Your Life Insurance benefit, whichever is less.

BENEFITSPLUS— QUALIFIED LIFE EVENT: If You have a Qualified Life Event, You may elect, drop, increase, or decrease certain Coverage Amounts. You must apply in writing within 30 days of the Qualified Life Event. Committed Partners are not eligible for Change in Status or Special Enrollment. If You wish to elect higher amounts than indicated in the chart below, then You may do so by providing Statement of Health, in writing within 30 days of the Qualified Life Event. Coverage that does not require evidence will go into effect as of the date of the Qualified Life Event. Coverage that does require evidence will go into effect the date the carrier approves Your Statement of Health. If the Insurance Carrier denies the Statement of Health You will receive the amount listed in the chart that does not require a Statement of Health.

You	• You may elect one times Your base annual pay • You may increase coverage by 1 level. • Rounding and benefit maximums apply.
Your Spouse	• You may elect $10,000 or $20,000.
Your Eligible Child	• You may elect or increase coverage to any level.

REGULAR PLAN—WAIVER OF PREMIUM FOR LIFE INSURANCE: If You are covered for Basic, Optional and/or Dependent Life under the Regular Plan and You become totally disabled before age 60, You may qualify for continued coverage at no cost to You. If You die during the continuation, proof of the death must be sent to the Insurance Carrier. In addition to the proof which is otherwise required for the insurance, the proof must show that Your total disability continued with no interruption from the date the Insurance Carrier informed You that the continuation was approved until the date of the death. When the Insurance Carrier receives such proof with the claim, the Insurance Carrier will review the claim and if the Insurance Carrier approves it, the Plan will pay any benefit payable under the insurance continued under this section.

•The amount of insurance eligible for Waiver of Premium is the amount in effect on the day before You become totally disabled, except that insurance may be reduced or terminated in accordance with the Group Policy provisions in effect on the day before You become totally disabled or in accordance with the Accelerated Benefit provisions. In addition, if You become insured under a group life insurance plan that replaces the Group Policy while You are eligible for Waiver of Premium, any death benefit payable under the Group Policy will be reduced by the amount payable under the replacement group life insurance plan.

•Premium payments must continue until the date the Insurance Carrier approves Your claim for Waiver of Premium. Insurance will not be affected by termination or amendment of the Group Policy after You become totally disabled. The Insurance Carrier may have You examined at reasonable intervals by a doctor of their choice.

• **Waiver of Premium ends** on the earliest of (i) the date You cease to be totally disabled, (ii) the date You reach age 65, (iii) 90 days following the date the Insurance Carrier requests additional information for continued Proof of Loss, if such information has not been provided, (iv) the date You fail to attend an examination or cooperate with the examiner, or (v) for the amount of insurance You port/convert, the date the conversion policy is issued.

• For the purposes of Waiver of Premium, totally disabled means that, as a result of accidental Injury, Sickness, or Pregnancy, during the first 12 Months You are eligible for Waiver of Premium You are unable to perform with reasonable continuity the material duties of Your Own Occupation and, thereafter, in the material duties of any gainful occupation for which You are reasonably fit by education, training, and experience.

STATEMENT OF HEALTH: Statement of Health is sometimes referred to as evidence of insurability. Statement of Health will be approved or denied by the Insurance Carrier. If Statement of Health is approved, then Your coverage will begin on or after the date of approval. If Statement of Health is not approved or You cannot provide any proof, then the coverage that You elected that required Statement of Health will not go into effect and You will be defaulted to the guaranteed issue amount. The chart below outlines when You must provide Statement of Health (SOH).

- If You are required to provide Statement of Health, then You must provide it at Your own expense. You must submit the Statement of Health form and submit it to the Insurance Carrier as described below and as directed by the Insurance Carrier. The Statement of Health will be e-mailed to your Company e-mail address within five business days of your enrollment. The Statement of Health must be completed within 60 days of when the e-mail is delivered to your Company e-mail address. If not completed, then your life insurance elections will default to the guaranteed issue amounts as stated above. It is your responsibility to complete this step following enrollment. Your coverage level(s) above the guaranteed issue amounts will not be effective if you do not submit the Statement of Health in accordance with the Insurance Carrier's requirements.

- In BenefitsPlus, Statement of Health is not required for Basic Life, AD&D, or Child/Committed Partner Child Life. In the Regular Plan, Statement of Health is not required for Basic Life/AD&D or Child Life.

	STATEMENT OF HEALTH
BenefitsPlus--Optional Life	- If You Enroll after You were first eligible as a new hire[1] - If Your Optional Life coverage ended because You failed to make a required premium contribution, You must provide SOH to become insured again (unless premium was not made during an approved leave of absence) and You elect the coverage again within 30 days after You return to work - If You elect more than three times Your Base Annual Pay[1] - If You elect to increase Your coverage[1] - If You had Optional Life in the Regular Plan immediately preceding enrollment in BenefitsPlus and elect coverage of (a) more than one times Your Base Annual Pay if You had $50,000 of Optional Life under the Regular Plan, (b) more than two times Your Base Annual Pay if You had $100,000 of Optional Life under the Regular Plan, or (c) more than three times Your Base Annual Pay if You had $150,000 of Optional Life under the Regular Plan - If Spouse/Committed Partner Life coverage ended because You failed to make a required premium contribution, except that this will not apply if (a) the required premium was not made during an approved leave of absence, and (b) You elect the same coverage amount within 30 days after You return to work
BenefitsPlus--Spouse/ Committed Partner Life	- If You Enroll after You were first eligible as a new hire[1] - If Spouse/Committed Partner Life coverage ended because You failed to make a required premium contribution, except that this will not apply if (a) the required premium was not made during an approved leave of absence, and (b) You elect the same coverage amount within 30 days after You return to work - If You elect more than $20,000 of coverage - If You elect to increase Your coverage[1]
Regular Plan--Optional Life/AD&D	- If You Enroll after You are first eligible as a new hire, - If You elect to increase Your coverage, - If You had Optional Life in BenefitsPlus immediately preceding enrollment in the Regular Plan and elect coverage of (a) $100,000 or $150,000, if You had Optional Life coverage under BenefitsPlus of one times Your Base Annual Pay, or (b) $150,000, if You had Optional Life coverage under BenefitsPlus of two times Your Base Annual Pay. - If Your optional life coverage ended because You failed to make a required premium while out on leave, and You return to work and elect the coverage again within 30 days after You return to work, no Statement of Health required.
Regular Plan--Spouse	- If You Enroll after You were first eligible as a new hire, or - If Spouse Life coverage ended because You failed to make a required premium contribution, except that this will not apply if (a) the required premium was not made during an approved leave of absence, and (b) You elect the same coverage amount within 30 days after You return to work.

[1] *Except as provided in the Chart of Allowed Changes for Change in Status/Special Enrollment in Section 1 of this SPD.*

AMOUNT OF AD&D BENEFIT FOR EACH TYPE OF LOSS: If You have an accident and the accident results in a loss, benefits will be paid according to chart below. Total benefits for losses resulting from the same accident will not exceed the AD&D Coverage Amount. A loss must meet all of the following requirements: (i) is caused solely and directly by accident; (ii) occurs independently of all other causes; (iii) occurs within 365 days of the accident; and (iv) with respect to loss of life, is evidenced by a certified copy of the death certificate, or with respect to all other losses, is certified by a Physician in the appropriate specialty as determined by the Insurance Carrier.

- You will be presumed dead if You disappear as the result of an accident for which the benefit would have been payable had You not disappeared, but only if the disappearance (i) is caused solely and directly by an accident that reasonably could have caused loss of life, (ii) occurs independently of all other causes, and (iii) continues for a period of 365 days after the date of accident, despite reasonable search efforts.

- Loss does not include the following:
  - physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
  - infection, other than infection occurring in an external accidental wound;
  - suicide or attempted suicide;
  - intentionally self-inflicted injury;
  - service in the armed forces of any country or international authority. However, service in reserve forces
  - does not constitute service in the armed forces, unless in connection with such reserve service an
  - individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
  - any incident related to: travel in an aircraft as a pilot, crew member, flight student, or while acting in any capacity other than as a passenger, except for a pilot or crew member of an aircraft owned or leased by or on behalf of the Policyholder; travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is inflight; parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation; travel in an aircraft or device used for testing or experimental purposes, by or for any military authority, or for travel or designed for travel beyond the earth's atmosphere;
  - committing or attempting to commit a felony;
  - the voluntary intake or use by any means of any drug, medication or sedative (unless it is taken or used as prescribed by a Physician or an "over the counter" drug, medication or sedative taken as directed), alcohol in combination with any drug, medication, or sedative, or poison, gas, or fumes; or
  - war, whether declared or undeclared; or act of war, participation in an insurrection, rebellion or riot.

TYPE OF LOSS	AMOUNT OF AD&D BENEFIT
Loss of Life	100% of AD&D Coverage Amount
Loss of a hand permanently severed at or above the wrist but below the elbow	50% of AD&D Coverage Amount
Loss of a foot permanently severed at or above the ankle but below the knee	50% of AD&D Coverage Amount
Loss of both hands permanently severed at or above the wrist but below the elbow	BenefitsPlus ONLY: 100% of AD&D Coverage Amount
Loss of both feet permanently severed at or above the ankle but below the knee	BenefitsPlus ONLY: 100% of AD&D Coverage Amount
Loss of sight[1] in one eye	50% of AD&D Coverage Amount
Loss of sight[1] in both eyes	BenefitsPlus ONLY: 100% of AD&D Coverage Amount
Loss of any combination of hand, foot, or sight of one eye	100% of AD&D Coverage Amount
Loss of the thumb and index finger of same hand[2]	BenefitsPlus ONLY: 25% of AD&D Coverage Amount
Loss of speech[3] and loss of hearing	BenefitsPlus ONLY: 100% of AD&D Coverage Amount
Loss of speech[3] or loss of hearing	BenefitsPlus ONLY: 50% of AD&D Coverage Amount
Loss of hearing[4] in one ear	BenefitsPlus ONLY: 25% of AD&D Coverage Amount
Paralysis[5] of both arms and both legs	BenefitsPlus ONLY: 150% of AD&D Coverage Amount
Paralysis[5] of both legs	BenefitsPlus ONLY: 75% of AD&D Coverage Amount
Paralysis[5] of the arm and leg on either side of the body	BenefitsPlus ONLY: 75% of AD&D Coverage Amount
Paralysis[5] of one arm or one leg	BenefitsPlus ONLY: 50% of AD&D Coverage Amount
Brain Damage[6]	BenefitsPlus ONLY: 100% of AD&D Coverage Amount
Coma[7]	BenefitsPlus ONLY: 1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 60 months.

[1]**Loss of sight** means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.
[2]**Loss of thumb and index finger of same hand** means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.
[3]**Loss of speech** means the entire and irrecoverable loss of speech that continues for six consecutive months following the accidental injury.
[4]**Loss of hearing** means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.
[5]**Paralysis** means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.
[6]**Brain Damage** means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.
[7]**Coma** means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

Exclusion for Intoxication: The Plan will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

BENEFITSPLUS ADDITIONAL AD&D BENEFITS: **The following additional benefits only apply to BenefitsPlus.**

- **Seat Belt Benefit:** If You die as the result of a covered automobile accident and You were wearing and properly utilizing a Seat Belt System (as evidenced by a police accident report), a Seat Belt Benefit may be payable.

- **Air Bag Benefit:** If You die as the result of a covered automobile accident and You are eligible for the Seat Belt Benefit, the automobile is equipped with an Air Bag System that was installed as original equipment by the Automobile manufacturer and has received regular maintenance or recommended scheduled replacement, and You are seated in the driver's or passenger's seating position intended to be protected by the Air Bag System and the Air Bag System deploys (as evidenced by a police accident report), the Air Bag Benefit may be payable.

- **Spouse Education Benefit:** If You die due to a covered accident, a Spouse Education Benefit may be payable, if all provisions are met.

- **Child Care Benefit:** If You die due to a covered accident, the Child Care Benefit may be payable, if all provisions are met.

- **Child Education Benefit:** If You die due to a covered accident, the Child Education Benefit may be payable, if all provisions are met.

- **Workplace Assault Benefit:** If You are assaulted while Actively at Work and suffer a covered loss, the Workplace Assault Benefit may be payable, if all provisions are met.

- **Common Carrier Benefit:** If You die due to an accidental injury, the Common Carrier Benefit may be payable, if all provisions are met.

- **COBRA Continuation Benefit:** If You die due to an accidental injury, the COBRA Continuation Benefit may be payable, if all provisions are met.

ACCELERATED DEATH BENEFIT: You may elect for Yourself and/or Your Spouse to receive an accelerated benefit on a specified portion of the amount of Life Insurance benefits otherwise payable upon the death of the Covered Individual, if You or any person enrolled for coverage by You and insured under the group policy are terminally ill and have at least $10,000 of coverage under Basic and Optional Life. You may elect this benefit option only once during Your lifetime while remaining covered under the Plan.

- For the purposes of this Accelerated Death Benefit provision, terminally ill means a medical condition resulting from an illness or physical condition which is reasonably expected to result in death within 24 Months.

- The Accelerated Benefit payment will be made in one lump sum to You or to the payee You appropriately assign. Contact the Insurance Carrier for the appropriate Accelerated Death Benefits Application and additional instructions.

- If You are in **BenefitsPlus,** You may elect to receive up to 80% of Your Basic and Optional Life coverage combined in effect on the acceleration date, not to exceed $620,000. Under this election, a minimum payment is required in the amount of the greater of (i) $1,000 or (ii) 10% of Your Life coverage.

- If You are in the **Regular Plan,** You may elect to receive up to 80% of the amount of Your Life coverage in effect on the acceleration date, not to exceed amounts set forth in the schedule of benefits included in the Certificate. Under this election, a minimum payment of $1,000 is required.

- Payment of the Accelerated Benefit will reduce the face amount of Your Life Insurance benefit and result in reduced Life Insurance proceeds payable to Your beneficiary at Your death.

- This benefit is subject to all other provisions and amendments of the Plan, including any provision or amendments providing reduction or termination due to age or retirement. Any reduction will be calculated based on Your Life Insurance amount in effect immediately before the Accelerated Benefit payment.

- Your AD&D coverage, if any, is not affected by payment of the Accelerated Benefit.

- Receipt of the Accelerated Benefit may be taxable and may affect Your eligibility for Medicaid or other government benefits or entitlements. However, if You meet the definition of "terminally ill individual" according to the Internal Revenue Code Section 101, Your Accelerated Death Benefit may not be taxable. You should consult Your personal tax and/or legal adviser before You apply for an Accelerated Death Benefit.

FILING A CLAIM: To file a claim You or Your beneficiary must contact the Insurance Carrier.

- **Proof of loss** means written proof that a loss occurred (i) for which benefits are provided for, (ii) which is not subject to any exclusions, and (iii) that meets all other conditions for benefits. Proof of loss includes any other information that is reasonably required in support of a claim. Proof of loss must be in writing and must be provided at the expense of the claimant. No benefits will be provided until proof of loss is received.

- Proof of loss for a waiver of premium under the Regular Plan must be provided within 12 Months after You become totally disabled. Further proof of loss is required at reasonable intervals, but not more often than once a Year after You have been continuously totally disabled for two Years.

- If proof of loss is filed after these time limits, the claim will be denied. These limits will not apply if You or Your beneficiary do not have the legal capacity to file a claim.

INVESTIGATION OF CLAIMS: The Insurance Carrier may have You examined at its expense at reasonable intervals and as often as is reasonably necessary while Your claim is pending and, except where prohibited by law, may have an autopsy performed at its expense. Any such examination will be conducted by a Provider of the Insurance Carrier's choice.

NOTICE OF DECISION ON CLAIM AND APPEAL PROCEDURES: The Insurance Carrier will evaluate a claim for benefits promptly after it is received. Such claims will be reviewed by the Claims Administrator in accordance with the Plan's Claims Procedures set forth in Section 1 of this SPD. Claims and appeals under the Life Insurance and AD&D Program are subject to the claims procedures in that section of the SPD governing (a) disability claims for Waiver of Premium claims and (b) non-disability claims under plans that are not group health plans for all other claims. However, for claims under the Life Insurance and Accidental Death and Dismemberment programs, there is only one level of appeal provided under the Plan, which shall serve as the Claim Administrator's final determination on Your claim for benefits.

DEADLINE FOR FILING A LAWSUIT: You cannot bring any legal action against Southwest or the Claims Administrator of the Life Insurance and AD&D Program to challenge an adverse claim determination under these programs unless You first complete all the steps in the benefit claims appeal process described above. After completing that process, if You want to bring a legal action against Southwest or the Claims Administrator, You must do so within three years of the earlier of the date Your employment ends or the date You are notified of the Claim Administrator's final decision on appeal; otherwise, You lose any rights to bring such an action against Southwest or the Claims Administrator.

PAYMENT OF CLAIMS: You will be paid the following benefits if You are living only after written proof of loss is received and approved by the Insurance Carrier: (i) AD&D Benefits other than loss of life (except when the benefits have been assigned, in which case such benefits will be paid to the assignee); (ii) Spouse/Committed Partner or Child Life/Committed Partner's Child Life benefits; and (iii) Accelerated Benefits.

- If You die while covered for Life and AD&D benefits, Your beneficiary will be paid the following benefits upon Your death, but only after written proof of Your death is received and approved by the Insurance Carrier: (i) Basic Life; (ii) Optional Life; and (iii) AD&D death benefits (if any).

- Payment will be made in one lump sum. Other payment schedules may be available upon request. Contact the Insurance Carrier for additional information. To the extent permitted by law, the amount payable will not be subject to any legal process or to the claims of any creditor or creditor's representative.

- If death occurs and the beneficiary is a minor (a person not of legal age) or the insured's estate, it may be necessary to have a guardian or a legal representative appointed before any death benefits can be paid. This means there could be legal charges for the beneficiary and a delay in benefit payment(s).

- If payment is made before receiving notice of change in Your beneficiary, then the Insurance Carrier will not pay the benefits a second time.

- AD&D Benefits payable for other than loss of life will be paid to the person who suffers the loss for which benefits are payable except when the benefits have been assigned, in which case such benefits will be paid to the assignee. Any such benefits remaining unpaid at the person's death will be paid according to the provisions for payment of a death benefit.

- The BenefitsPlus additional benefits are paid as follows. The child care benefit will be paid to Your surviving Spouse; however, no child care benefit will be paid if You have no Spouse at the time of Your death. The Career Adjustment Benefit will be paid to Your Spouse if within 36 Months after the date of Your death, Your spouse is registered and in attendance at a professional or trades training program for the purpose of obtaining employment or increasing earnings; however, no Career Adjustment Benefit will be paid if You have no Spouse. The Higher Education Benefit will be paid annually to each eligible Child; however, no Higher Education Benefit will be paid if there is no Child eligible to receive it. The Repatriation Benefit will be paid to the person who incurs the transportation charges.

BENEFICIARIES: When You Enroll in the Life and AD&D Insurance Program, You must name a beneficiary who will receive Your benefit if You die. You may name anyone You want. You must name one or more primary beneficiaries (who receive Your benefit first) and one or more contingent beneficiaries (who receive Your benefit if Your primary beneficiary dies before receiving it). Your beneficiary designation must be the same for Life and AD&D Insurance death benefits.

- You may designate or change Your beneficiary at any time on the MetLife website at www.metlife.com/mybenefits.

- If You name more than one primary or contingent beneficiary, then You must specify what percentage of Your benefit each person will receive. If You do not specify, Your benefit will be divided equally among all surviving primary beneficiaries (or all surviving contingent beneficiaries if no primary beneficiaries survive).

- If You provide for unequal shares and a beneficiary dies before You, then the Insurance Carrier will pay the benefit to any remaining beneficiaries in accordance with their designated shares. Unless You provide otherwise, the Insurance Carrier will then pay the share(s) otherwise due to any deceased beneficiaries to the surviving beneficiaries pro rata based on their designated percentages.

- If You do not name a beneficiary for the Life Insurance and AD&D Program or if no beneficiary survives You, then the Insurance Carrier will pay in order to (i) Your surviving Spouse (or if in BenefitsPlus Your surviving Committed Partner), (ii) Your surviving children in equal amounts, (iii) Your surviving parents in equal amounts, (iv) Your surviving brothers or sisters in equal amounts, or, finally, (v) Your estate.

- If a beneficiary or one of the person's named above dies on the same day You die, or within 15 days thereafter, then Benefits will be paid as if that beneficiary or person had died before You, unless proof of loss with respect to Your death is delivered to the Insurance Carrier before the date of the beneficiary's death.

- If You have Spouse/Committed Partner or Child Life/Committed Partner Child Life coverage, then You are automatically the beneficiary and any benefits which are unpaid at Your death will be paid in equal shares to the following in order (i) the children of the deceased Spouse/Committed Partner/Child/Committed Partner's Child, (ii) the parents of the deceased Spouse/Committed Partner/Child/Committed Partner's Child, (iii) the brothers and sisters of the deceased Spouse/Committed Partner/Child/Committed Partner's Child, or (iv) Your estate.

ASSIGNMENT OF BENEFITS: You may make an absolute assignment and transfer of ownership of Your Basic and Optional Life and AD&D insurance if the amount of Your insurance is at least $25,000. You may not assign Spouse/Committed Partner and Child Life/Committed Partner's Child Life insurance. The assignment must be in writing, signed by You, be absolute and irrevocable, and transfer all rights including the rights to change the beneficiary, to port/convert the policy to an individual policy, and to receive accidental dismemberment benefits. The assignment may be made to any person other than the policyholder or Employer and will apply to all life and AD&D insurance then in effect and becoming effective after that date.

- Neither the Insurance Carrier, the policyholder, nor the Employer will be responsible for the validity of any assignment, nor liable for any action, payment or other settlement made before the assignment is received.

- AD&D benefits for losses other than loss of life will be paid to the assignee. All death benefits will be paid according to the beneficiary designation on file with the policyholder or Employer and the other provision of the Group Policy. The assignment will not change the beneficiary unless the assignee later changes the beneficiary. Any payment made in accordance with the beneficiary form on file and the terms of the Group Policy will fully discharge the Insurance Carrier to the extent of the payment.

TIME LIMITS ON LEGAL ACTIONS AND CERTAIN DEFENSES: No action at law or in equity may be brought until 60 days after You have given Proof of Loss. No such action may be brought more than three Years after the earlier of (i) the date Proof of Loss is received or (ii) the time within which Proof of Loss is required to be given. Any statement made to obtain or to increase insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim unless (i) the insurance would not have approved if the truth had been known and (ii) You or any other person claiming benefits have been given a copy of the signed written instrument which contains the misrepresentation. The misrepresentation will not be used to reduce or deny a claim after the insured's insurance has been in effect for two Years during the lifetime of the insured.

INCONTESTABILITY OF GROUP POLICY: Any statement made by the policyholder or Employer to obtain the Group Policy is a representation and not a warranty. No misrepresentation by the policyholder or Employer will be used to deny a claim or to deny the validity of the Group Policy unless (i) the Group Policy would not have been issued if the Insurance Carrier had known the truth and (ii) the policyholder or Employer has been given a copy of a written instrument signed by the policyholder or Employer which contains the misrepresentation. The validity of the Group Policy will not be contested after it has been in force for two Years, except for nonpayment of premiums.

CLERICAL ERROR: A clerical error made by the policyholder, Your Employer, or their respective Employees or representatives will not (i) cause a person to become insured, (ii) invalidate insurance otherwise validly in force, or (iii) continue insurance otherwise validly terminated.

MISSTATEMENT: If a person's age has been misstated, equitable adjustment of premiums, benefits, or both will be made based on (i) the amount of insurance based on the correct age and (ii) the difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

POLICYHOLDER AND EMPLOYER NOT AGENTS OF CARRIER: The policyholder and the Employer act on their own behalf as the Employee's agent, not the Insurance Carrier's agent.

GROUP POLICY ALLOCATION OF AUTHORITY: Except for functions that the Group Policy reserves to the policyholder, the Insurance Carrier has full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy. The Insurance Carrier's authority includes, but is not limited to: (i) the right to resolve all matters when a review has been requested; (ii) the right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it; and (iii) the right to determine eligibility for insurance, entitlement to benefits, amount of benefits payable, and sufficiency and the amount of information the Insurance Carrier may reasonably require to determine eligibility for insurance, entitlement to benefits and the amount of benefits payable. Subject to the claim review procedures, any decision made by the Insurance Carrier in the exercise of their authority is conclusive and binding.

TERMINATION OR AMENDMENT OF THE GROUP POLICY: The Life and AD&D Insurance Program is provided pursuant to a Group Policy. The Group Policy may be terminated by the Insurance Carrier or the policyholder according to the Group Policy terms. It will terminate automatically for nonpayment of premium. The policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving written notice to the Insurance Carrier. Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of the Insurance Carrier's executive officers and given to the policyholder for attachment to the Group Policy. If the terms of this SPD differ from the Group Policy, the terms of the Group Policy will govern. The policyholder, Your Employer, and their respective Employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without the Insurance Carrier's written approval. The Insurance Carrier may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects its obligations under the Group Policy, or with the policyholder's consent. Any change or amendment of the Group Policy may apply to current or future participants or to any separate classes or groups of participants.

BENEFITSPLUS—PORTABILITY OF INSURANCE (TERM LIFE): If Your coverage ends due to termination of employment or leave of absence, You may elect to continue Your Life Insurance and AD&D coverage with a term life policy under Portability of Insurance, if covered, as long as You port Your coverage and apply and pay the first premium within 31 days from the date coverage ends.

- Portable group insurance will become effective the day after Your insurance ends under the Group Policy, if You apply within 31 days after the date Your insurance ends under the Group Policy.

- If You purchase ported coverage and death occurs within 31 days after the date insurance ends under the Group Policy, life insurance benefits, if any, will be paid according to the terms of the Group Policy in effect on the date Your insurance ends under the Group Policy and not the terms of the Group Life Portability Insurance Policy. AD&D benefits, if any, will be paid according to the terms of the Group Policy or the Group Life Portability Insurance Policy, but not both. In no event will the benefits paid exceed the amount in effect under the Group Policy on the day before Your insurance ends.

- Any insurance You port will be under a separate policy issued to a separate group insurance trust. That policy will contain provisions that differ from the coverage described in this Plan.

- Portability is offered in all 50 states.

- You must complete a new beneficiary designation if You port your coverage. Beneficiary designations that you filed while receiving benefits under the Plan are not valid after coverage under the Plan ends.

- AD&D is portable under BenefitsPlus only.

CONVERTING COVERAGE (WHOLE LIFE): If Your coverage ends due to termination of employment or leave of absence, You may have the right to port/convert Life insurance coverage (including coverage continued under the Waiver of Premium available in the Regular Plan) to an individual whole life policy. AD&D coverage may not be ported or converted.

- You may convert Your coverage if Your coverage, or any portion of it, ends for any reason other than Your failure to make a required premium contribution or the payment of an accelerated benefit. The amount of the ported or converted policy may not be more than the amount reduced or ended.

- To convert coverage You must apply in writing within 31 days after Your Life Insurance is reduced or ends for any reason other than Your failure to pay the required premium or payment of an Accelerated Benefit, and You must pay the initial premium, based on Your age at the time of the conversion, within the 31-day period.

- If You convert coverage, then the individual policy will become effective on the day after the conversion period. You may select any form of individual Life Insurance policy issued by the Insurance Carrier based on Your age, except You may not select term life, universal life, a policy with disability, accidental death, or other additional benefits, or a policy in an amount less than the minimum amount the Insurance Carrier issues for the form of Life Insurance You select.

- If You or Your Covered Family Member dies during the 31-day conversion period, then the maximum amount that You or the Covered Family Member could have ported or converted will be payable to Your beneficiary even if You or Your Covered Family Member did not apply for a conversion of benefits.

- If Family Member is a minor or is not legally able to apply for a conversion policy, a parent or guardian may apply for a conversion policy on behalf of the covered Family Member.

- Examples of situations when You may choose to port/convert coverage include the end of Your employment for any reason, the end of Your eligibility, the end of Your eligibility for this benefit, or reaching a specified age. Your Covered Family Member may port/convert coverage if coverage, or any portion of it, ends for any reason other than Your failure to make a required premium contribution, including Your death, the end of Your employment for any reason, or the end of Your eligibility.

- If Your insurance ends or is reduced because of a termination or amendment of the Group Policy, You may not port/convert insurance which has been in effect for less than 5 years.

- You will be required to name a beneficiary for Your ported or converted Policy. The beneficiary You name under the Group Policy will no longer be valid.

END OF SECTION

LONG TERM DISABILITY INSURANCE PROGRAM

GENERAL INFORMATION: The Long Term Disability Insurance Program is an insured product. Southwest offers you the opportunity to purchase Long Term Disability Insurance to help provide for you and your family in the event that you become disabled and cannot work for an extended period of time. Pilots are not eligible but may elect long term disability coverage through SWAPA. The Certificate from the Insurance Carrier is available on SWALife. To the extent there are any discrepancies between this SPD and the Certificate for this Program, then the Certificate shall govern.

- In **BenefitsPlus**, you will receive Basic LTD coverage at no cost to you. If you want more coverage you may elect the Optional Taxable or Optional Non-Taxable LTD benefit options. In the **Regular Plan**, you may elect Optional Non-Taxable LTD.

Basic LTD—Any benefit payments you receive will be subject to Federal Income, Social Security, and Medicare taxes.
Optional Taxable LTD—A portion of the benefit payments you receive, if any, will be subject to Federal Income, Social Security, and Medicare taxes.
Optional Non-Taxable LTD—The benefit payments you receive, if any, are not subject to Federal Income, Social Security, and Medicare taxes.

	BENEFITSPLUS			REGULAR PLAN
	BASIC	OPTIONAL TAXABLE BENEFIT	OPTIONAL NON-TAXABLE BENEFIT	OPTIONAL NON-TAXABLE BENEFIT
ELIGIBILITY	ALL EMPLOYEES EXCEPT PILOTS			
MONTHLY LTD BENEFIT (WILL BE REDUCED BY DEDUCTIBLE INCOME)	40% of Base Monthly Pay	60% of Base Monthly Pay	60% of Base Monthly Pay	50% of Base Monthly Pay for Customer Service, Ramp, Operations, Freight, Provisioning, Customer Representatives (Agents/Supervisors), Flight Attendants, Skycaps 60% of Base Monthly Pay for all other Eligible Employees
MAXIMUM BENEFIT PER MONTH (BEFORE REDUCTION BY DEDUCTIBLE INCOME)	$10,000	$10,000	$10,000	$3,000 per Month for Customer Service, Ramp, Operations, Freight, Provisioning, Customer Representatives (Agents/Supervisors), Mechanics, Aircraft Appearance Technicians, Skycaps $5,000 per Month for Flight Attendants $10,000 per Month for all other Eligible Employees
BENEFIT WAITING PERIOD	180 days	90 days	90 days	180 Days for Flight Attendants 90 Days for all other Eligible Employees
MINIMUM BENEFIT PER MONTH	10% of gross benefit or $100, whichever is greater	10% of gross benefit or $100, whichever is greater	10% of gross benefit or $100, whichever is greater	$50
TAX IMPACT ON BENEFIT PAYMENTS	Taxable	A portion is Taxable	Not Taxable	Not Taxable

- The Plan does not cover disabilities caused or contributed to by (i) participation in war or any act of war, (whether declared or undeclared, civil, or international), (ii) any substantial armed conflict between organized forces of a military nature, or (iii) intentionally self-inflicted injury while sane or insane.

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PRE-EXISTING CONDITION LIMITATION: The Insurance Company will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" for purposes of the LTD Program means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services including diagnostic measures, or took prescribed drugs or medicines within twelve months before his or her most recent effective date of insurance. This Pre-existing Condition limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after an Employee has been Actively at Work for a continuous period of twelve months during which the Employee has received no medical treatment, care or services in connection with the pre-existing conditions or is covered for at least 24 months after his or her most recent effective date of insurance, or the effective date of any added or increased benefits.

- If an Employee's employment with the Employer terminates and he or she is rehired within thirty days, then this Pre-Existing Condition limitation will be based on his or her original date of coverage under the policy.

- If an Employee is not Actively at Work under the policy and he or she is reinstated and returns to Active Work within ninety days, then this Pre-Existing Condition limitation will be based on his or her original date of coverage under the policy. The Employee will need to satisfy a new Pre-Existing Condition limitation period if he or she is reinstated and returns to Active Work more than ninety days.

- **If You <u>are not</u> Actively at Work on the effective date of coverage,** a preexisting condition is a mental or physical condition for which You have consulted a doctor, received medical treatment and/or services, or taken prescription drugs or medication during the **12 Month** period just before the date Your coverage became effective. If, during the 12 Months before coverage took effect, services are rendered or supplies are received in connection with a pregnancy or a pregnancy is confirmed, the pregnancy is a pre-existing condition whether or not the pregnancy commenced during the 12 Month period.

- After Your Monthly LTD benefits for a period of disability end, Your coverage will continue without any interruption and without application of the preexisting condition exclusion provided (i) You immediately return to Active Work, (ii) You are eligible, and (iii) You enroll for coverage in the same LTD option.

PREMIUMS: Premiums for LTD coverage will be based on Your Base Monthly Pay and Your job classification. Your Base Monthly Pay is determined depends on Your job classification and rate of pay on the day before a period of disability started.

	BASE MONTHLY PAY
FLIGHT ATTENDANTS	Your individual rate of pay per trip times 94 trips
HOURLY FULLTIME EMPLOYEES	Your hourly rate of pay times 2,080 hours divided by 12
OTHER FULLTIME EMPLOYEES	Your Monthly rate of pay
HOURLY PARTTIME EMPLOYEES	Your hourly rate of pay times 1,040 hours divided by 12

- Base Monthly Pay includes Your salary and wages including contributions You make through a salary reduction agreement with Your employer to an IRC Section 125 Plan for Your fringe benefits, an IRC 401(k), 403(b), or 457 deferred compensation arrangement, and an executive nonqualified deferred compensation agreement. Other than regular earnings, Base Monthly Pay does <u>not</u> include overtime, per diem, awards, commissions, bonuses, contributions made by Your employer to a deferred compensation arrangement, or other compensation.

- Your indexed Base Monthly Pay will equal Your Base Monthly Pay as of the date You became disabled until You have been disabled for at least one Year. Following Your first full Year of disability, on each January 1 Your Base Monthly Pay will be indexed (increased) by the lesser of (i) 10% of Your indexed Base Monthly Pay during the preceding Year of Your disability or (ii) the rate of increase in the Consumer Price Index during the preceding Calendar Year multiplied by Your indexed Base Monthly Pay during the preceding Year of Your disability. If there is a decrease in the Consumer Price Index, Your indexed Base Monthly Pay will not decrease.

- If You were on a leave of absence or not at work (whether or not You were scheduled to work) on the date before Your rate of pay or job classification change, Your Base Monthly Pay will not change until You return to Active Work.

- Your LTD coverage in effect when You become disabled will be continued without payment of premiums while Monthly LTD benefits are payable.

ELIGIBILITY: To be eligible to receive an LTD benefit in any LTD option, Flight Attendants must have flown an average of at least 30 trips per Month in the preceding six consecutive calendar Months (or during the period of employment if less than six Months). All other eligible Employees must be regularly working at least 20 hours each week in the preceding six consecutive calendar Months (or during the period of employment if less than six Months). **Pilots are not eligible for the LTD Program.**

To be eligible to receive a benefit, You must be disabled and under the Appropriate Care of a Physician in the appropriate specialty as determined by the Insurance Carrier. You will not be deemed to be under the regular care of a Physician more than 31 days before the date he or she has seen and treated You in person for the disease or Injury that caused the disability. If Your occupation requires a professional or occupational license or certification of any kind, You will not be deemed to be disabled solely because of the loss of that license or certification. If You suffer a loss of pre-disability earnings as a result of the disclosure of any disease or Injury; You will not be deemed to be disabled solely because of the loss of pre-disability earnings.

- You are required to be disabled from Your Own Occupation. If You are an eligible Employee, after 24 Months You are required to be disabled from all occupations.

- **You are disabled from Your Own Occupation** if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, You are either (i) unable to perform with reasonable continuity the Material Duties of Your Own Occupation or (ii) unable to earn more than 80% of Your indexed Base Monthly Pay while working in Your Own Occupation. Under this definition of disability, You will be considered disabled while working in another occupation if You are disabled from Your Own Occupation. There is no limit on the amount You can earn from work in another occupation while You are disabled from Your Own Occupation. Your earnings will be used in determining the amount of Your Monthly LTD benefit. **You are disabled from all occupations** if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, You are either (i) unable to perform, with reasonable continuity, the Material Duties of any gainful occupation for which You are reasonably fitted by education, training or experience or (ii) unable to earn more than 50% of Your indexed Base Monthly Pay while working in Your Own Occupation or any other occupation.

- **Your period of disability will end according to the charts below.**

BENEFITSPLUS	REGULAR PLAN
Your period of disability will end on the later of: • the calendar Month in which You reach normal retirement age, as determined by the 1983 Amended Social Security Normal Retirement Age Table (see below), or • the expiration of the number of Months of disability after the Benefit Waiting Period is met as figured from the following schedule:	Your period of disability will end on the later of: • the calendar Month in which You reach age 65, or • the expiration of the number of Months of disability after the Benefit Waiting Period is met as figured from the following schedule:

MAXIMUM BENEFIT DURATION SCHEDULE

Age When Disability Begin	Maximum Benefit Duration
< 63	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69+	12 Months

MAXIMUM BENEFIT DURATION SCHEDULE

Age When Disability Begins	Maximum Benefit Duration
< 63	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69+	12 Months

1983 AMENDED SOCIAL SECURITY NORMAL RETIREMENT AGE TABLE

YEAR OF BIRTH	NORMAL RETIREMENT AGE
<1938	65
1938	65 and 2 Months
1939	65 and 4 Months
1940	65 and 6 Months
1941	65 and 8 Months
1942	65 and 10 Months
1943-1954	66
1955	66 and 2 Months
1956	66 and 4 Months
1957	66 and 6 Months
1958	66 and 8 Months
1959	66 and 10 Months
1960+	67

BENEFIT WAITING PERIOD: Your Benefits begin after You have completed Your Benefit Waiting Period (the length of time You must be continuously disabled before Your benefit begins). Your Benefit Waiting Period begins on the date You become disabled as determined by the Insurance Carrier. Benefits are never payable during the Benefit Waiting Period.

- If You temporarily recover during the Benefit Waiting Period, all separate periods of disability from the same cause or causes will be combined and treated as one period of continuous disability as long as the total number of recovery days does not exceed 30. Periods of temporary recovery will not count toward Your Benefit Waiting Period.

	BENEFIT WAITING PERIOD
BenefitsPlus Basic LTD **Flight Attendants—Regular Plan Optional LTD**	180 Days
BenefitsPlus Optional Taxable LTD **BenefitsPlus Optional Non-Taxable LTD** **Regular Plan Optional LTD (except Flight Attendants)**	90 Days

BENEFITS: Your Base Monthly Pay in effect as of the date You became disabled will be used to compute Your Monthly benefit amount during Your period of disability. Two or more separate periods of disability resulting from the same or related causes may qualify for treatment as one continuous period of disability. If so, Your Base Monthly Pay used to compute Your Monthly benefit amount for each separate period of disability will be the same amount as for the initial period of disability.

- Your Monthly LTD benefit will equal the lesser of (i) Your Monthly benefit amount reduced by Your Deductible Income or (ii) the maximum benefit amount; however, it will not be less than the minimum benefit. If there is an overpayment, then the overpayment may be recovered from any payment due.

- Your right to receive Monthly LTD benefits for a period of continuous disability which begins while You are insured under this Plan will not be affected by (i) the termination of the Plan after the date You become disabled or (ii) any amendment to the Plan approved after the date You become disabled.

MAXIMUM BENEFIT PERIOD: Your maximum benefit period is the longest period of time for which Monthly LTD benefits are payable for any one period of continuous disability from one or more causes. Your maximum benefit period begins at the end of Your Benefit Waiting Period. Your Monthly LTD benefit will end on the earliest of (i) the date of Your death, (ii) the date when You have reached the maximum benefit period, even if You are still disabled, or (iii) the date You no longer qualify for a Monthly LTD benefit. In addition, Monthly LTD benefits are limited to 24 Months for each period of continuous disability caused or contributed to by a Mental Disorder; however, if You are confined in a Hospital at the end of the 24 Months, this limitation will not apply while You are continuously confined.

- If a period of continuous disability is extended by a new cause while Monthly LTD benefits are payable, Monthly LTD benefits will continue while You remain disabled subject to the terms of the Plan; however, (i) Monthly LTD benefits will not continue beyond the end of the original maximum benefit period and (ii) no Monthly LTD benefits will be paid for any extension of a period of continuous disability caused or contributed to by an exclusion listed under the Plan.

- If You temporarily recover during the maximum benefit period and become disabled again from the same or related cause or causes, Your two periods of disability will be treated as one continuous period, if they are separated by a recovery period of less than six Months. If You are a Mechanic or Aircraft Appearance Technician enrolled in Optional LTD under the Regular Plan, two periods of disability will be treated as one continuous period if separated by a period of less than one Year. If Your two periods of disability qualify as one continuous period, then a new Benefit Waiting Period will not be required, Your Base Monthly Pay used to compute Your Monthly LTD benefit will not change and the maximum benefit period will be the balance of the maximum benefit period remaining unused before the period of recovery. LTD benefits will not be payable for any period of temporary recovery.
- No Monthly benefits will be payable after benefits become payable to You under any other group long term disability insurance policy. This prevents double coverage if You become insured under another policy while You are working during a period of temporary recovery.

YOUR DUTY TO PURSUE DEDUCTIBLE INCOME: You must pursue Deductible Income for which You may be eligible. The Insurance Carrier may ask for written documentation of Your pursuit of Deductible Income. You must provide it promptly after the Insurance Carrier mails You the request. Otherwise, the Insurance Carrier may reduce Your LTD benefits by the amount they estimate You would be eligible to receive upon proper pursuit of the Deductible Income.

OTHER BENEFITS:

The Insurance Company will assume the Employee (and his or her dependents, if applicable) are receiving benefits for which they are eligible from Other Income Benefits. The Insurance Company will reduce the Employee's Disability Benefits by the amount from Other Income Benefits it estimates are payable to the Employee and his or her dependents. The Insurance Company will waive assumed receipt of benefits, except for Disability Earnings (for work the Employee performs while Disability Benefits are payable), if the Employee: (i) provides satisfactory proof of application for Other Income Benefits; (ii) signs a Reimbursement Agreement; (iii) provides satisfactory proof that all appeals for Other Income Benefits have been made unless the Insurance Company determines that further appeals are not likely to succeed; and (iv) submits satisfactory proof that Other Income Benefits were denied. The Insurance Company will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until the Employee actually receives them.

You must notify the Insurance Carrier of other income you received. An employee for whom Disability benefits are payable may be eligible for Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits. For purposes this Other Income Benefit provision for the LTD Program, dependents include any person who receives (or is assumed to receive) benefits under any applicable law because of an Employee's entitlement to benefits.

Other Income Benefits include:

any amounts received (or assumed to be received) by the Employee or his or her dependent under the Canada and Quebec Pension Plans, the Railroad Retirement Act, any local, state, provincial or federal government disability or retirement plan or law, payable for Injury or Sickness provided as a result of employment with the Employer, any sick leave or salary continuation plan of the Employer if total benefits exceed 100% of the Employee's pre-disability earnings, and any work loss provision in mandatory "No-Fault" auto insurance;

any Social Security disability or retirement benefits the Employee or any third party receives (or is assumed to receive) on his or her own behalf or for his or her dependents; or which his or her dependents receive (or are assumed to receive) because of his or her entitlement to such benefits;

any Retirement Plan benefits funded by the Employer ("Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the Employer, however, it does not include an individual deferred compensation agreement, a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.);

any proceeds payable under any group insurance or similar plan (If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, the Insurance Company will pay for its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.);

any amounts received (or assumed to be received) by the Employee or his or her dependents under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury or Sickness arising out of work with the Employer, including all permanent and temporary disability benefits including any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted;

any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined;

RETURN TO WORK INCENTIVE: The return to work incentive provides encouragement for You to return to work during and after Your Benefit Waiting Period. During Your Benefit Waiting Period You may work if You meet the definition of disability. After the Benefit Waiting Period, You are eligible for the Return to Work incentive on the date You first return to work if Monthly LTD benefits are payable on that date.

- During the first twelve Months that You return to work while Monthly LTD benefits are payable, Your Monthly LTD benefit will be reduced only by Your work earnings that when added to Your Monthly LTD benefit, without any reduction for Other Income Benefits, are more than 100% of Your Indexed Base Monthly Pay. After the fist twelve Months that You return to work, Your Monthly LTD benefit will be reduced by one-half of Your work earnings. Work earnings are Your gross Monthly earnings from work performed while You are disabled, including earnings from Southwest, any other employer, or self-employment.

• Your gross Monthly earnings does not include any renewal commissions, overwriting renewal commissions, or service fees received on business sold before the date the period of disability started. In addition, any income received from another employer will be considered gross Monthly earnings only to the extent that it exceeds the amount of income You were receiving from such employer immediately before the date a period of disability started.

• If You are paid in a lump sum or on a basis other than Monthly, then Your income will be prorated on a Monthly basis over the period of time for which income applies. If a period of time is not indicated, then the insurance carrier will pro-rate the income over a reasonable period of time.

APPROVED REHABILITATION PROGRAM: An approved rehabilitation program may allow for payment of the Employee's medical expense, education expense, moving expense, accommodation expense or family care expense while he or she participates in the program. It may also include, but is not limited to the following benefits (i) coordination with the Employer to assist the Employee return to work; (ii) adaptive equipment or job accommodations to allow the Employee to work; (iii) vocational evaluation to determine how the Employee's disability may impact his or her employment options; (iv) job placement services; (v) resume preparation; (vi) job seeking skills training; or (vii) education and retraining expenses for a new occupation..

• If You are a participant in BenefitsPlus during Your active participation in an Approved Rehabilitation Program, then the Insurance Carrier will pay You an additional 10% of Your Monthly benefit after all applicable reductions for Other Income Benefits up to a maximum of $500 Monthly. This additional benefit will be paid for a maximum of six consecutive Months for each period of disability.

BENEFITSPLUS—CHILD CARE BENEFIT: For a period not to exceed 24 Months, if (i) You are a participant in BenefitsPlus, (ii) enrolled in an Approved Rehabilitation Program, (iii) have a dependent child that is under age 13 who is Your or Your Spouse's biological child or legally adopted child or for whom You are legal guardian, and (iv) Monthly LTD benefits have been payable for 6 Months, then You may be eligible for a Child Care Benefit equal to the reimbursement of the Monthly charges for a licensed day care Provider (not including immediate family or anyone who lives in Your residence) of $250/child/Month but not to exceed $500 per Month.

BENEFITSPLUS—EDUCATION BENEFIT: If Your are a participant in BenefitsPlus and if Monthly benefits have been payable for 6 Months, an additional benefit will be paid equal to $100 for each of Your children who is an Eligible Student during such Month. An Eligible Student is Your unmarried dependent child (including Your b biological or legally adopted child or one who lives with You and is either Your spouse's biological or legally adopted child or a child for whom You are legal guardian). who is under 22 Years of age and attending an accredited post-secondary school on a full-time basis. Full-time means a full course load as defined by the accredited post-secondary school. A child will be deemed to be an Eligible Student between terms as long as the child will be attending school on a full time basis in the following term.

BENEFITSPLUS—BENEFIT ESCALATOR: If You are a participant in BenefitsPlus, an additional benefit will be payable equal to 10% of Base Monthly Pay prior to Your disability up to a maximum of $2,500 (not subject to adjustment of other income) if You are disabled and a Monthly benefit is payable under the Plan and You suffer a Functional Loss following the date You are covered for this benefit.

• A Functional Loss means (i) due to physical incapacity resulting from disease or injury, You are unable to perform (without substantial assistance) at least two Activities of Daily Living (ADL) for a period of 90 days or (ii) due to Cognitive Impairment, You require substantial supervision in order to protect You and others from serious threats to health and safety. ADL includes bathing, transferring, dressing, toileting, continence, and eating. Cognitive Impairment means a deterioration or loss in Your intellectual capacity that is measured by clinical evidence and standardized tests which reliably measure impairment in short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

PAYMENT OF BENEFITS: During the maximum benefit period, Monthly LTD benefits are paid at the end of each Monthly period for which You qualify for benefits. All Monthly LTD benefits will be paid to You. Any Monthly LTD benefit remaining unpaid at the time of Your death will be paid to the person or persons receiving the Survivors Benefit. If no Survivors Benefit is paid, the unpaid benefits will be paid to Your estate. **You may not assign the benefits payable for Your claim.**

FILING A CLAIM FOR BENEFITS AND CLAIMS PROCEDURES: Call the Insurance Carrier to file a claim for benefits. The Insurance Carrier may require You to fill out a claim form and/or submit other documents at Your expense. The Insurance Carrier will require You to submit additional documentation of Your claim at Your expense at reasonable intervals while You are receiving Monthly LTD benefits. Such claims will be reviewed by the Claims Administrator for the LTD Program in accordance with the Plan's claims procedures set forth in Section 1 of this SPD. Claims and appeals for disability benefits are subject to those portions of the claims procedures that apply to disability claims. However, for claims under the LTD Program, there is only one level of appeal provided under the Plan, which shall serve as the Claim Administrator's final determination on Your claim for benefits.

INVESTIGATING YOUR CLAIM: The Insurance Carrier has the right at any time to conduct an investigation of Your claim. The Insurance Carrier has the right to have You examined at their expense at reasonable intervals while You are claiming benefits. Any such examinations will be conducted by one or more Physicians or vocational specialists of the Insurance Carrier's choice. The Insurance Carrier has the right to deny or suspend payment of Monthly LTD benefits if You fail to attend an examination or fail to cooperate with the person conducting the examination.

PROOF OF LOSS: No benefits will be paid until the Insurance Carrier receives satisfactory written proof of loss demonstrating that (i) You became disabled while insured under this Plan, (ii) You were disabled throughout the Benefit Waiting Period and the period for which benefits are claimed, (iii) Your disability results from a cause not excluded under this Plan, (iv) You are being seen regularly and treated by a Physician approved by the Insurance Carrier, and (v) any additional information as the Insurance Carrier may reasonably require.

- At any time, the Insurance Carrier may request additional documentation to support Your claim. If You do not provide the documentation promptly after the Insurance Carrier mails You their request, then Your claim may be denied.

- If Your claim is approved, LTD benefits will be paid within 60 days after You satisfy proof of loss. No Monthly LTD benefits will be continued beyond the end of the period for which You have provided the Insurance Carrier with satisfactory written proof of loss.

- You must give proof of loss to the Insurance Carrier within 90 days after the end of the Benefit Waiting Period. If You cannot do so, You must submit proof of loss as soon thereafter as reasonably possible and, in any case, within one Year after the end of that 90-day period. Proof of loss not filed within these time limits will result in Your claim being denied and no Monthly LTD benefit will be paid. These limits will not apply during any period when You lacked the legal capacity to file a claim.

TIME LIMITS ON LEGAL ACTIONS AND CERTAIN DEFENSES: No action at law or in equity may be brought to recover under this Plan until 60 days after written proof of loss has been provided to the Insurance Carrier. No such action may be brought more than three Years after the earlier of (i) the date written proof of loss is received by the Insurance Carrier or (ii) the end of the period within which written proof of loss is required to be given.

SURVIVOR BENEFITS: The survivor benefit is paid to the Spouse. If there is not a Spouse, it is divided equally among any children. If there are no children, it is paid to the estate.

MISSTATEMENT: Any statement You make to obtain or increase coverage will be a representation and not a warranty. No misrepresentation by You will be used to reduce or deny Your claim or to contest the validity of Your coverage unless (i) Your coverage would not have been approved if the Insurance Carrier had known the truth, (ii) Your misrepresentation is contained in a written instrument signed by You, and (iii) You have been given a copy of the written instrument containing Your misrepresentation. After Your coverage has been in effect for two Years, no misrepresentation by You, except a fraudulent misrepresentation, will be used to reduce or deny Your claim or to contest the validity of Your coverage.

END OF SECTION

BENEFITSPLUS: FLEXIBLE SPENDING ACCOUNTS

If you are electing BenefitsPlus Choice Plus Plan or Choice Plan C medical options then you may choose to participate in the Health Care FSA.

If you are electing BenefitsPlus Choice Plus Plan, Choice Plan C, or the Health Savings Plan medical option then you may choose to participate in the Dependent Care FSA.

Expenses Eligible for Reimbursement	Health Care FSA	Dependent Care FSA
What is the Benefit Used for?	Qualified medical expenses ONLY.	Qualified day care expenses ONLY.
Choice Plus Plan	Yes	Yes
Choice Plan C	Yes	Yes
Can it be elected if enrolled in the Health Savings Plan option?	No	Yes

- To participate in the Flexible Spending Account Program, you must make an election each Year. Your elections will not roll over from Year to Year. If you choose to participate, then you must determine the amount that you would like to contribute annually. The annual contribution amount will be prorated across your paychecks throughout the Year. Your Monthly flexible spending account contribution(s) will be withheld from your paychecks before taxes.

- Amounts contributed to an FSA do not carry-over from Year-to-Year. Due to Internal Revenue Service regulations, You lose any money left in the Health Care FSA or Dependent Care FSA on December 31 of the Plan Year, for which you do not have eligible expenses. You have until March 31 of the next Plan Year, to file for reimbursement of the prior Plan Year's expenses. You may only file claims for eligible expenses that are incurred during the same calendar year for which You make Your deposits. You may not carry over deposits from one year to the next and you forfeit any amounts left in Your account.

- **You may not transfer funds between the Health Care FSA, the Dependent Care FSA, and the Health Svings Account (HSA).**

BENEFITSPLUS: HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HEALTH CARE FSA)

GENERAL: If You are enrolled in the BenefitsPlus option You may enroll in the Health Care FSA Program. The Health Care FSA is a way for You to save money tax-free to use on eligible healthcare expenses, including Deductibles, Copayments, and Coinsurance, for You and members of Your family that qualify as dependents for federal income tax purposes. The Health Care FSA allows You to withhold amounts from Your paycheck for deposit to a spending account that may be used to reimburse You for qualifying health care expenditures during the Year. Special circumstances may affect Your claims. Your deposits will be held in trust until You file a claim for reimbursement. The trust does not credit Your Health Care FSA with interest.

- **You must make qualified eligible healthcare charges by Year end to use the money You deposit to the Health Care FSA. You have until March 31 of the next Year to file claims for eligible healthcare charges incurred through the previous December 31.**

- The following is not intended to constitute tax advice; and it is recommended that You consult Your personal tax advisor. Your deposits to Your Health Care FSA that are deducted from Your pay reduce the amount of taxable income on Your W-2 form for federal income taxes, Social Security and Medicare (FICA) taxes, and most state and local income taxes. You may not take a deduction on Your income tax return and receive reimbursement from the Health Care FSA for the same expense.

- If you have a Change in Status, You may increase or decrease your deposits in certain circumstances.

DEPOSITS: You choose the annual amount of Your Health Care FSA deposit on Your hire date and each Year at annual enrollment. You cannot change the amount of Your deposit during the Year, even if You have a Qualified Life Event. Unless noted elsewhere in this SPD, the amount You deposit is deducted from Your pay before federal income, Social Security, Medicare, and most state and local taxes are withheld. The result is that You pay eligible healthcare charges with tax-free dollars. Deposits that are not made through payroll deductions generally will be made on an after-tax basis.

Deposits	
Minimum Deposit	$120 per Year
Maximum Deposit	$2,500 per Year

- You must enter the annual amount that You will deposit in the online enrollment system during Your enrollment period and Your deposits generally will be taken out of Your paychecks in equal amounts during the Year.

REIMBURSEMENT: You may file claims to reimburse eligible healthcare charges up to the amount of Your total annual contribution less prior reimbursements.

- You will automatically be enrolled in the automatic payment option when You enroll in the Health Care FSA . This allows the Claims Administrators to automatically reimburse You for eligible healthcare expenses from Your Health Care FSA when processing Medical, Dental, and Vision claims. When a claim is processed under these Programs, the portion of any eligible healthcare expense not covered by the Plan under these Programs will automatically be paid out of Your Health Care FSA up to the annual amount You have elected to contribute less prior reimbursements.

- **You <u>must</u> terminate Your automatic payment option if You (i) have other insurance coverage that may be responsible for the charges, (ii) do not want your eligible healthcare expenses automatically reimbursed, (iii) have a Committed partner, or (iv) if You only want to be reimbursed for certain charges.** To terminate Your automatic payment option go to myuhc.com. If You terminate Your automatic payment option, or if You want to file a claim for other eligible out-of-pocket healthcare charges, You should follow the steps below.

- **Steps to File a Claim Manually**
  1. Obtain a flexible spending account Claim Submission/Withdrawl Request Form from www.swalife.com or myuhc.com.
  2. Complete the form and attach Your itemized receipts and, if Your claim was denied or partially covered by the Medical (including prescription drug), Dental, or Vision Program or other insurance, attach an Explanation of Benefits or proof of Your out-of-pocket charges.
  3. Return the completed form along with the appropriate receipts or documentation to the Claims Administrator at the address on the form. Keep a copy of all documentation.
  4. Claims are processed daily and reimbursement checks are mailed to Your home address. Alternatively, You may elect to have reimbursements deposited directly into Your personal bank account by enrolling in Health Care FSA direct deposit at myuhc.com. Claims are generally paid once the total amount of claims submitted exceeds $25.
  5. Your claim will be processed in accordance with the Plan's Claims Procedures set forth in Section 1 of this SPD. Claims and appeals for benefits under Your Health Care FSA are subject to those portions of the claims procedures that apply to group health plans.

ELIGIBLE HEALTHCARE CHARGES: **You may only file claims for reimbursement for eligible healthcare charges and it is Your responsibility to determine what the IRS considers to be an eligible healthcare expense.** If You have questions, contact the Health Care FSA Claims Administrator.

- You may file a claim to reimburse eligible healthcare charges for You, Your Spouse and individuals who You may claim as dependents on Your federal income tax return, even if the individuals are not covered or eligible for coverage under Southwest's benefit plans. If You are divorced, Your child is generally treated as Your dependent for this purpose even if You may not claim the child as Your dependent on Your federal income tax return. The Internal Revenue Code determines whether an individual may be claimed as a dependent on Your federal income tax return. You should consult with your personal tax advisor if You have a Committed Partner. You may refer to IRS Publication 501 available at www.irs.gov for a detailed description of whom You may claim as a dependent.

- You may only file claims for eligible healthcare charges that are incurred (i) while You are a participating member of the Health Care FSA and (ii) during the same Calendar Year for which You make Your deposits. An expense is considered incurred when the care or service is provided, not when You are billed for or pay for the care or service. The portion of the charges for healthcare is separated from any charges for non-healthcare services or supplies. For a complete and current detailed list of eligible healthcare charges and ineligible charges, You may refer to IRS Publication 502 at www.irs.gov. The IRS and courts may modify this list at any time. Note that Publication 502 describes the rules for deducting healthcare charges on Your tax return and therefore refers to the time at which an expense is paid rather than the time at which the expense is incurred. **As described above, eligible healthcare charges under the Health Care FSA are determined on an incurred basis rather than a time of payment basis.**

- If You intend to use the Health Care FSA for infertility treatment, you should consult with Your tax advisor. Many expenses incurred in connection with infertility treatment programs do not qualify as eligible medical charges.

- If Your medical Provider offers a concierge practice, note that generally concierge fees are not reimbursable because they are not for medical care. For additional information, consult IRS resources or Your tax advisor.

QUALIFIED RESERVIST DISTRIBUTIONS: If You are called to active military duty, You may be eligible to withdraw the balance in Your Health Care FSA as a Qualified Reservist Distribution. You are only eligible if You (i) You are a member of a reserve component (as defined in 37 U.S.C. Section 101) ordered or called to active duty for a period of 180 days or more for an indefinite period, and (ii) the request for distribution is made during the period beginning with the order or call to active duty and December 31 of the same Year.

- **You must complete the Qualified Distribution Request Form and provide Southwest with a copy of the order or call to active duty before a Qualified Reservist Distribution may be made.**

- The amount of Your Qualified Reservist Distribution will be the amount contributed to the Health Care FSA as of the date of the distribution minus all Health Care FSA requests for reimbursement received as of the date of the Qualified Reservist Distribution request. Partial distributions will not be permitted. If You would like to submit a claim for reimbursement for medical charges incurred prior to the date that You request a Qualified Reservist Distribution, then You must submit such claims prior to or concurrent with submitting Your request for a Qualified Reservist Distribution. Such claims if qualified will be reimbursed and will reduce the amount of Your Qualified Reservist Distribution.

- If eligible, Qualified Reservist Distributions will be made within sixty days of Southwest's receipt of Your completed Qualified Distribution Request Form. Incomplete submissions will be deemed not received. If a Qualified Reservist Distribution is made, Your right to submit claims and Your Health Care FSA will terminate. A Qualified Reservist Distribution may not be made with respect to a plan Year ending before the order or call to active duty.

- You must be called to active duty; You may not make a Qualified Reservist Distribution because Your spouse is called to active duty. If Your initial order or call to duty is for a period of less than 180 days, although You are not initially eligible for a Qualified Reservist Distribution, if Your order or call is extended such that the cumulative order or call is at least 180 days, then You may be eligible for a Qualified Reservist Distribution.

- The following is not intended to constitute tax advice; and it is recommended that You consult Your personal tax advisor. A Qualified Reservist Distribution will be included in Your gross income and wages and will be subject to applicable employment taxes. The amount of Your Qualified Reservist Distribution will be included in Your Form W-2 for the Year in which the Qualified Reservist Distribution is paid. The amount reported as wages will be reduced by any amount in Your Health Care FSA representing after-tax contributions (e.g., COBRA continuation premiums).

COMPARISON TO HSA

Comparison Chart	Health Care FSA	Health Savings Account
Medical Program Requirement	**BenefitsPlus Choice Plus Plan and Choice Plan C ONLY**	**BenefitsPlus Health Savings Plan (HSP) ONLY**
Must be used by Year End? ("Use it or Lose it")	YES	NO
Annual Contribution Limit?	$2,500	$3,250 Employee Only Coverage $6,450 Family Coverage (Family Coverage includes: Employee + Spouse, Employee + Children)
Roll-over option when Terminate or Retire?	NO	YES
Qualified medical Expenses only?	YES	YES
Pre-Tax Contributions?	YES	YES*
Can be elected if enrolled in the BenefitsPlus Health Savings Plan Option?	YES	YES

* Pre-tax payroll contributions may only be made to a Health Savings Account with Optum Bank. If you open your Health Savings Account with another bank, contributions cannot be pre-tax payroll deducted, although they may be considered a tax deduction when filing your annual tax return. Consult your tax advisor for details.

BENEFITSPLUS: Dependent Care Flexible Spending Account (Dependent Care FSA) Program

GENERAL: The Dependent Care FSA allows You to withhold amounts from Your paycheck for deposit to a spending account that may be used to reimburse You for qualifying dependent care expenditures during the Year. Special circumstances may affect Your claims. Your deposits will be held in trust until You file a claim for reimbursement. The trust does not credit Your Dependent Care FSA with interest.

- You must make eligible dependent care expenses by Year end to use the money you have deposited to the Dependent Care FSA. You have until March 31 of the next Year to file claims for eligible dependent care charges incurred through the previous December 31. After that, You will forfeit all amounts remaining in your Dependent Care FSA.

If you do not have child or adult daycare or other qualifying care expenses, then you should not enroll in the Dependent Care FSA. If you enroll in the Dependent Care FSA in error, contributions may not be refunded due to federal tax law requirements.

TAX CONSIDERATIONS: The following is not intended to constitute tax advice; and it is recommended that You consult Your personal tax advisor.

- If You participate in the Dependent Care FSA, You may not take a dependent care tax credit on Your income tax return and receive reimbursement from the Dependent Care FSA for the same expense. Any amounts deposited to the Dependent Care FSA offset Your dependent care tax credit maximums dollar for dollar.

- Your deposits in the Dependent Care FSA that are deducted from Your pay reduce the amount of taxable income on Your W-2 form for federal income taxes, FICA (Social Security and Medicare) taxes, and most state and local income taxes.

- The federal dependent care tax credit (or a combination of the tax credit and the Dependent Care FSA) may provide more tax relief than the Dependent Care FSA alone. This depends on Your eligibility for the earned income tax credit and/or the child tax credit, how many eligible dependents You have, and the amount of Your dependent care charges. You should consult with a professional tax adviser to determine which program (or combination of programs) would be the most beneficial to You.

DEPOSITS: Your deposits to the Dependent Care FSA are generally made through payroll deductions. You choose the amount of Your deposit to the Dependent Care FSA during Your initial new hire enrollment and each Year at annual enrollment. You may change the amount of Your deposit to the extent You have a Qualified Life Event as explained in this SPD. The amount You elect to deposit may not exceed Your earned income or Your Spouse's earned income, whichever is less. You are responsible for ensuring that Your deposits do not exceed Your earned income or Your Spouse's earned income.

Status	Minimum Monthly Deposit	Maximum Monthly Deposit	Maximum Annual Deposit
Single	$10	$416.66	The lesser of $5,000 or Your annual earned income
Married filing a joint tax return	$10	$416.66	The least of $5,000, Your annual earned income, or Your Spouse's annual earned income
Married filing a separate tax return	$10	$416.66	The least of $2,500, Your annual earned income, or Your Spouse's annual earned income

For each Month in which Your Spouse is a fulltime student or is a qualifying dependent due to physical or mental incapacity, Your Spouse will be considered to have earned income of not less than $250 per Month if You have one qualifying dependent and not less than $500 per Month if You have two or more qualifying dependents. For example, if Your Spouse is a fulltime student for 8 Months during the Year, has no other income, and You have two qualifying dependents, Your Spouse will be considered to have earned income of $4,000 for the Year.

- You may not transfer deposits from the Dependent Care FSA to the Health Care FSA, or vice-versa. You also may not carry over deposits from one Year to the next.

REIMBURSEMENT: You may file a claim only to reimburse Eligible Dependent Care Charges incurred for the care of a qualifying dependent, and up to the net amount in Your Dependent Care FSA (deposits less prior reimbursements) as of the date You file Your claim.

- You may only file claims for Eligible Dependent Care Charges that are incurred during the same Calendar Year for which You make Your deposits. You may continue to spend-down amounts in Your Dependent Care FSA after You terminate Your participation in the Dependent Care FSA provided that You only file claims that meet the requirements of the Dependent Care FSA Program.

- **Steps To File a Claim**
  1. Obtain a flexible spending account Claim Submission/Withdrawal Request Form from www.swalife.com or www.myuhc.com.
  2. Complete Your portion of the form and have the child care, elder care or dependent care Providers complete their portion of the form or attach itemized receipts from the Provider, which includes the Provider's tax identification number.
  3. Return the completed form along with the appropriate receipts to the Claims Administrator at the address on the form. Keep a copy of all documentation.
  4. Claims are processed daily and reimbursement checks are mailed to Your home address. Alternatively, You may elect to have reimbursements deposited directly into Your personal bank account by enrolling at myuhc.com. Claims are generally paid once the total amount of claims submitted exceeds $25.

- You may be required to provide proof of any claim. It is Your responsibility to: (i) determine what the IRS considers to be an Eligible Dependent Care Expense; (ii) file only claims for Eligible Dependent Care Charges; and (iii) keep a copy of Your documentation for all claims.

- Claims under the Dependent Care FSA Program will be processed in accordance with the Plan's Claims Procedures set forth in Section 1 of this SPD. Claims and appeals for benefits under Your Dependent Care FSA are subject to those portions of the claims procedures that apply to non-disability claims under plans that are not group health plans.

ELIGIBLE DEPENDENT CARE CHARGES: You may receive reimbursements from the amount You deposit to the Dependent Care FSA if:

- You incur Eligible Dependent Care Charges (see below); and
- the Eligible Dependent Care Charges are for the care of one or more qualifying dependents; and
- if You are married:
  - -Your Spouse also works outside the home,
  - -Your Spouse is a fulltime student at least five Months during the Calendar Year, or
  - -Your Spouse is mentally or physically unable to take care of himself or herself.

- For purposes of the Dependent Care FSA Program, **You are not considered married** if You are (i) legally separated under a decree of divorce or separate maintenance or (ii) if You file a separate federal income tax return, maintain a household in which Your qualifying dependent resides for more than half the Year, furnish over half the cost of maintaining such household, and Your Spouse does not reside in such household during the last six Months of the Year.

- Eligible Dependent Care Charges under the Dependent Care FSA are determined on an incurred basis rather than a time of payment basis. An expense is considered incurred when the care or service is provided, not when You are billed for or pay for the care or service.

- You may only file claims for Eligible Dependent Care Charges that are incurred to enable You to be gainfully employed or to actively search for gainful employment. In general, the portion of Your charges for child care, elder care or dependent care must be separated from Your charges for other goods or services (such as education, meals, clothing or chauffeuring), unless the other charges are for minimal or insignificant household services or are incidental to and inseparable from the care of the qualifying dependent.

- For a complete and current detailed list of Eligible Dependent Care Charges and ineligible charges, You may refer to IRS Publication 503 at www.irs.gov. Publication 503 describes the rules for the child and dependent care tax credit and has different rules for determining the Year in which an Eligible Dependent Care Expense must be incurred and paid. In general, You may not reimburse expenses for care at a camp where your qualifying dependent stays over-night (e.g., no sleep away camps). For additional information consult Your tax advisor or IRS guidance.

QUALIFYING DEPENDENTS: For purposes of the Dependent Care FSA program, **qualifying dependents** include:

- a person who You claim as a qualifying child dependent on Your federal income tax return and who is under the age of 13;
- a person who You claim as a qualifying child or qualifying relative dependent on Your federal income tax return, who is physically or mentally incapable of caring for himself or herself, and who resides in Your home for more than half the Year; and
- Your Spouse if he or she is physically or mentally incapable of caring for himself or herself and resides in Your home for more than half the Year.

- **Qualifying dependents** must be a qualifying dependent on the date when the Eligible Dependent Care Expense is incurred but are not required to be covered or eligible for coverage under any other Plan benefit.

- If You are divorced and are the "custodial parent" (as defined in the Internal Revenue Code) of Your qualifying child who is under the age of 13 or who is physically or mentally incapable of caring for himself or herself, the child will be considered Your qualifying dependent even if You do not claim the child as a dependent on Your federal income tax return.

- The Internal Revenue Code defines the terms "qualifying child" and "qualifying relative" and contains rules for determining whether You may claim a qualifying child or qualifying relative as a dependent on Your federal income tax return. Generally, an individual must not be married filing a joint federal income tax return and must be a citizen of the United States or a resident of the United States, Canada, or Mexico to qualify as a dependent. You may refer to IRS Publication 501 at www.irs.gov for a detailed description of whom You may claim as a dependent.

END OF SECTION

ADOPTION ASSISTANCE EXPENSE REIMBURSEMENT PROGRAM

GENERAL INFORMATION: Adopting a child can be a very exciting experience for families, but also a sizable financial commitment. The Adoption Assistance Expense Reimbursement Program assists Southwest Employees who are building families and may need assistance with adoption expenses.

ELIGIBILITY: Regardless of whether you enroll in any other benefit programs, if You are an active Fulltime or Parttime Employee of Southwest and You are eligible to participate in the Medical Program, then You may participate in the Adoption Assistance Expense Reimbursement Program. If both You and Your Spouse are eligible Employees of Southwest, only one of You may utilize this benefit. Neither children nor any other Family Member or Committed Partner of an eligible Employee may receive reimbursements or benefits under this Plan.

- An Employee will no longer be eligible to participate in the Adoption Assistance Expense Reimbursement Program on the earliest of: (i) the date the Employee terminates employment, including the expiration of an authorized leave of absence without returning to employment; (ii) the date on which the Plan terminates; or (iii) the date on which the Employee is no longer eligible to participate in the Medical Program.

- Benefits under the Adoption Assistance Expense Reimbursement Program will be made available to eligible Employees on a nondiscriminatory basis. Benefits under the Adoption Assistance Expense Reimbursement Program will be limited to the extent necessary to ensure that the Adoption Assistance Expense Reimbursement Program does not discriminate in favor of highly compensated or key Employees.

TAX CONSIDERATIONS: The Adoption Assistance Expense Reimbursement Program is designed to provide benefits which You may be able to exclude from Your federal taxable income. What follows is a brief discussion of tax considerations. It is not intended as tax advice, and You are strongly encouraged to consult with a professional tax advisor regarding the tax consequences of receiving benefits under the Adoption Assistance Expense Reimbursement Program.

- All or a portion of reimbursements under the Adoption Assistance Expense Reimbursement Program may qualify for exclusion from Your federal taxable income, depending on Your adjusted gross income and Your compliance with certain filing and other requirements. If Your adjusted gross income exceeds the IRS established limit, the exclusion of Adoption Assistance Expense Reimbursement Program benefits is phased out until no Plan benefits are excludable. For additional information on federal income tax exclusion and limits, refer to www.irs.gov. Generally, if You are married, You must file a joint tax return if Adoption Assistance Expense Reimbursement Program benefits are excluded from Your federal taxable income. If an adopted child is not a citizen or resident of the United States (or a Unites States' possession), benefits payable under the Adoption Assistance Expense Reimbursement Program will not be excludable from Your federal taxable income unless the adoption is finalized.

- If benefits paid under the Adoption Assistance Expense Reimbursement Program are not excludable from Your gross income for federal income tax purposes, You are responsible for reporting the nonexcludable amount on Your federal tax return. In such a case, You must also pay any tax owed on such amounts by making any necessary adjustments to Your income tax withholding or by making estimated tax payments so as to avoid potential penalties for underpayment of tax.

- Reimbursements under the Adoption Assistance Expense Reimbursement Program are subject to applicable Social Security and Medicare taxes, and such taxes will be withheld from any reimbursements paid to You. If reimbursements under the Adoption Assistance Expense Reimbursement Program are excluded from Your income for federal income tax purposes, such reimbursements will offset on a dollar-for-dollar basis any adoption tax credit allowable under the Internal Revenue Code for personal income tax purposes.

ELIGIBLE CHILD: To qualify for benefits under the Plan, the child being adopted must be an Eligible Child. A child is an Eligible Child if at the time a Qualified Adoption Assistance Expense is incurred, the child is (i) not a stepchild of an Employee and (ii) under the age of 18.

QUALIFIED ADOPTION ASSISTANCE CHARGES: Qualified Adoption Assistance Charges which are incurred by You while You are an eligible Employee may be reimbursed under the Plan up to a maximum of $2,000 per adopted child. No benefits are payable under the Plan unless the adoption is finalized.

- The lifetime maximum for benefits reimbursed to You and Your Spouse (if any) under the Adoption Assistance Expense Reimbursement Program is $4,000. If You and Your Spouse are both Southwest Employees, only one of You may participate in the Adoption Assistance Expense Reimbursement Program and receive Adoption Assistance Expense Reimbursement Program benefits. This means that You and Your Spouse (if any) may not receive reimbursements under the Adoption Assistance Expense Reimbursement Program of more than $4,000 over Your lifetime and Your Spouse's lifetime even if Your Spouse is also an eligible Employee of Southwest. Whether or not You have continuously participated in or been eligible to participate in the Plan, any benefit payments previously received by You or Your Spouse will apply to Your and Your Spouse's lifetime maximum benefit and per child benefit.

- If You receive a reimbursement from the Adoption Assistance Expense Reimbursement Program and reimbursement for the same expense is made from any other source, then You will be required to refund the reimbursement from this Adoption Assistance Expense Reimbursement Program to Southwest by payroll deduction or by such other method as is requested by Southwest.

- Qualified Adoption Assistance Charges include, but are not limited to, the reasonable and necessary charges directly related to, and with the principal purpose of, the legal adoption of an Eligible Child by an eligible Employee. All other requirements of the Adoption Assistance Expense Reimbursement Program must be satisfied before any charges will be reimbursed.

ELIGIBLE CHARGES	INELIGIBLE CHARGES
- Agency and placement fees	- Charges incurred prior to the effective date of the Plan
- Legal fees and court costs	- Charges You are not legally required to pay
- Medical charges of the child which are incurred after the child is placed for adoption with You but before the adoption is finalized, and which are not reimbursed through the Medical Program	- Voluntary donations or contributions (such as amounts donated to a religious or charitable organization in connection with the adoption)
- Temporary foster care costs if part of the adoption process	- Charges incurred in violation of federal or state law
- Immigration, immunization, and translation fees	- Charges related to or for any surrogate parenting arrangement
- Transportation, lodging and meal charges while away from home	- Charges for which You received funds under any federal, state or local program
	- Charges related to the legal adoption of a stepchild of an Employee
	- Charges incurred prior to the date You are eligible to participate in this Plan
	- Charges incurred after the date You are no longer eligible to participate in this Plan
	- Charges for which a deduction or credit is allowed under any provision of the Internal Revenue Code

FILING A CLAIM: To submit qualified adoption assistance charges, You must provide all of the documents listed below to the Southwest Health & Wellness Team at Headquarters within 6 Months after the date the adoption is finalized.

1. A copy of the legal adoption order signed by a judge
2. Original or copies of itemized invoices (in U.S. dollars) for all charges
3. A copy of the adopted child's amended birth certificate that includes Employee's name
4. A completed Adoption Assistance Claim Form

Adoption Assistance Claim Forms are available on SWALife>About Me>My Benefits. Your claim will be considered only after the above information has been received. If Your claim is approved, the Adoption Assistance Expense Reimbursement Program will reimburse You for Qualified Adoption Assistance Expense You have incurred, up to the applicable maximum benefit.

Claims under the Adoption Assistance Program will be processed in accordance with the Plan's Claims Procedures set forth in Section 1 of this SPD. Claims and appeals for benefits under the Adoption Assistance Program are subject to those portions of the claims procedures that apply to non-disability claims under plans that are not group health plans.

END OF SECTION

WELLNESS PROGRAM

GENERAL INFORMATION: Southwest offers a number of programs to help with Your wellness goals. As a participant in the Plan, You may be entitled to certain wellness benefits or program incentives, as described below (the "Wellness Program"). These wellness opportunities are offered to You to help you lead a healthier lifestyle and take an active role in Your own personal health. Some of these wellness opportunities are not provided under this Plan but are made available to You as an Employee or Family Member, and these other non-Plan wellness benefits are also described below. Your participation in the Wellness Program is completely voluntary.

The discounts or other incentives described above are designed to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is Yours alone, but we recommend that You discuss participating in such programs with Your Physician. These programs do not require You to satisfy any health standards and do not alter or affect the provision of Your medical benefits. Additional information about our wellness programs is available on our intranet at SWALife>AboutMe>MyWellness. For more information or questions, please email Ask.Wellness@wnco.com.

WELLNESS BENEFITS PROVIDED UNDER THE PLAN: If You have elected health benefit coverage under the BenefitsPlus medical plan coverage option offered under the Plan, then You (and in some instances noted below, Your Family Members) are eligible for the following wellness programs and benefits. For the wellness programs offered under the Plan, Southwest may receive summary (i.e., de-identified) information under some of these programs regarding the participation and health of our Plan participants overall, and additionally, we may receive information on Your participation status, which is a reflection of your participation in the program, not a measure of Your health itself. However, we will not receive any of Your personal health information under any of these programs provided under the Plan.

- **Diabetes Prevention Program:** Employees who test positive for type 2 diabetes are eligible for pharmacy-sponsored health coaching to help manage their diabetes through regularly scheduled private consultations with a pharmacist trained in diabetes management. These benefits will be coordinated with Your primary care Physician. If You do not test positive for type 2 diabetes, but Your diabetes screening results in a "pre-diabetes" assessment, You will be eligible for a 16-week diabetes prevention program designed to help You make lifestyle changes to help lower Your risk of developing type 2 diabetes. Each of these benefits under the Diabetes Prevention Program is available to You at no additional cost if You are an Employee enrolled in a BenefitsPlus option under the Medical Program.
- **Metabolic Syndrome Program:** Southwest offers a metabolic syndrome program designed to give our Employees the opportunity to lose weight, feel better, and decrease risk factors for metabolic syndrome. This program is available on a pilot program basis to a select group of Employees enrolled in a BenefitsPlus Medical Program option, who are at risk for, or have been diagnosed with, metabolic syndrome. Participants for this program are selected by the program vendor, generally with the highest need accepted first and based on the applicants' current risk factors for metabolic syndrome, as determined by Your completed application and biometric screening results. The metabolic syndrome program is paid in full by Southwest so long as you complete the minimum participation requirements of the program. If you enroll in the metabolic syndrome program but do not complete the entire metabolic syndrome, you will be responsible for a $100 program fee.
- **Biometric Screenings:** Each Employee is provided access to onsite or offsite screenings that may include mammograms, blood pressure, glucose, A1C, cholesterol (lipid levels), bone density, and any other screenings that the Plan may add from time to time. Following the screenings, You will be able to access Your personal results online.
- **Tobacco Cessation Program:** You have access to a tobacco cessation program, which is a self-paced, confidential program to help You quit smoking or using smokeless tobacco. If You enroll, then You will participate in five outbound calls from a health coach and will have unlimited inbound calling for twelve Months to accomplish Your goal.
- **Flu Shots:** All Employees and their Family Members who are covered under BenefitsPlus medical care option are eligible to receive at no charge flu shots that may be offered under the Plan once a Year at one or more of our domestic offices.

OTHER WELLNESS BENEFITS PROVIDED OUTSIDE THE PLAN: The following wellness benefits are made available Employees of Southwest. You are not required to enroll in any particular company-sponsored health benefit coverage option to take advantage of these wellness benefits or opportunities. For those components of our Wellness Program that are offered outside the Plan, Southwest may have access to specific information regarding your participation in these programs; however, any information we obtain will be kept confidential and used only for purposes of administering these programs. In no event will any specific health information be used for any purposes related to your employment or affect the provision of Your medical benefits under the Plan.

- **The Vtrim® Program:** The *Vtrim* Program is a 12-week online weight management course led by live expert facilitators. As an Employee or Family Member, You are eligible for enrolling in this program at a discounted rate. If You are enrolling in this program due to a medical condition, this cost will qualify as an eligible expense for purposes of reimbursement under the Health Care FSA. You may be asked to submit a statement of medical necessity to receive this reimbursement.
- **Fitness Membership Discounts:** Courtesy discounts for membership at national and/or local fitness centers are provided by the fitness centers and made available to all Employees.
- **Weight Watchers®:** The Weight Watchers® weight management program is provided with a courtesy discount for all Employees and their Family Members.
- **Health & Safety Events:** From time-to-time, Southwest sponsors various health and safety events. Health and Safety Fairs are one-day events featuring various health & safety vendors. At Lunch and Learn sessions, invited speakers will present on various health-related topics at luncheon seminars.
- **Fitness Technology:** Southwest offers an online health and fitness platform where Employees can participate in fitness challenges, weight loss competitions, and nutrition challenges to focus on health and fitness-related goals.

END OF SECTION

INTERNATIONAL BUSINESS TRAVEL—URGENT AND EMERGENCY MEDICAL COVERAGE:
If your work for Southwest requires you to travel internationally, Southwest through Aetna WorldTraveler an international business medical plan that provides full-time Employees with emergency and urgent medical insurance and assistance while traveling out of the country on company business. This is offered to you automatically and enrollment is not required. For additional information about the International Business Travel—Urgent and Emergency Medical Coverage, see SWALife or contact the Health & Wellness Team at askbenefits@wnco.com.

- Coverage is provided for all international cities outside of the United States and Puerto Rico up to $250,000 per Year per Employee.

- Leisure travel is not covered.

- The Insurance Carrier provides services 24/7 including identifying local medical providers for You that have already been thoroughly researched and selected for quality of care, facilitating payment for medical services including treatment at hospitals, case monitoring, medical record transfers, and preferred access to medical clinics.

- In the event of an emergency, seek care and then contact Aetna International Customer Service at 877-242-5580 or collect at 813-775-0246. To see urgent care, search for a local health care provider online at www.AetnaInternational.com or contact 877-301-5042 or collect at 813-775-0239. You must provide the following information: Your name; Your Employer's name (Southwest); Your Aetna International World Traveler Company ID # 299440-10-103; and a description of Your situation.

BENEFITSPLUS –SUPPLEMENTAL HOSPITAL INSURANCE:
Supplemental Hospital Insurance is an insured product. Southwest offers this option to Employees enrolled in the BenefitsPlus program to provide an additional cash resource in the event that You or a qualified family member is hospitalized. There are no health questions or medical exams required to purchase this insurance.

- Certain exclusions apply to Supplemental Hospital Insurance including, but not limited to: (i) an individual that is pregnant as of the coverage effective date will not be eligible for a Supplemental Hospital Insurance benefit for days in the hospital in connection with maternity and (ii) treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including complications is also excluded. For a complete list of exclusions You may review details in the materials from Combined Worksite Solutions that are posted on SWALife>About Me>My Benefits> Information and Forms.

- If You purchase Supplemental Hospital Insurance, You will be eligible for up to $2,500 in payments per Year for You and each qualified family member. Upon Your or a qualified family member's initial confinement to the hospital, You will receive $750. For each additional day in a regular hospital room during the Year, You will receive an additional $250 per day up to three days. For each additional day in an ICU hospital room during the Year, You will receive an additional $250 per day up to four days.

- **Supplemental Hospital Insurance does not replace coverage that You have under Your BenefitsPlus medical option. Supplemental Hospital Insurance benefits are paid directly to You in cash to help You cover costs that may arise during Your time in the hospital. You could use the money to pay Deductibles or Coinsurance in connection with Your hospital stay or you could use the money to pay for any other need (e.g., Your mortgage).**

BENEFITSPLUS –AUTO/HOME INSURANCE: The Auto/Home Insurance program is an insured product provided by MetLife Auto & Home (although note that home insurance is not offered in Florida or Massachusetts) that provides Employees enrolled in BenefitsPlus Homeowners Insurance at discounted rates. Call MetLife at 877-638-7515 to request a quote and enroll. MetLife Auto & Home will obtain quotes from multiple insurance companies to determine your proposed rate.

BENEFITSPLUS –PET INSURANCE: The Pet Insurance program is an insured product provided by Veterinary Pet Insurance (VPI). Southwest used its sizable purchasing power to give Employees enrolled in the BenefitsPlus program the opportunity to purchase Pet Insurance at discounted rates. VPI policies cover wellness care as well as significant medical incidents. Pet Insurance offers you the chance to manage the risk associated with your pet's medical issues. Contact VPI at (800) 438-6388 for additional information.

WAGEWORKS: The Commuter Benefits Program administered by WageWorks lets You pay for Your eligible transit expenses through automatic, pre-tax payroll deductions. It works virtually anywhere You do. Submit an online order to get Your transit pass delivered to Your home every Month. Go online to **www.getwageworks.com/southwest** for additional information or to enroll.

TRAVEL ASSISTANCE:

As a perk for Employees enrolled in the AD&D Program, at no additional cost to You, travel assistance is available to help You when traveling for business or pleasure 100 miles or more from home.

- Travel Assistance offers You and Your dependents medical, travel, legal, financial, and concierge services, 24 hours a day, 365 days a Year, while traveling internationally or domestically. With one quick toll-free phone call, you will receive assistance in obtaining the help You need through more than 600,000 pre-qualified Providers worldwide.

- **Travel and Financial Services Include:**
  - General travel information about visa, passport, inoculation requirements and local customs
  - Telephone interpretation
  - 24-hour pre-departure information (weather, currency, holidays)
  - Emergency cash/ bail assistance/legal referrals
  - Lost document and luggage assistance

- **Medical Assistance Services Include:**
  - Physician/hospital/ dental referrals
  - Hospital admission validation
  - Evacuation and repatriation
  - Prescription transfer
  - Transportation to join patient
  - Return of mortal remains

- When Your AD&D coverage becomes effective, You may print an identification card from SWALife >About Me>My Benefits >Information & Forms, along with an informative brochure that highlights the available services. If You become sick or injured, require travel or financial assistance when traveling 100 miles or more from home, call the number on the identification card to access services. You will promptly be connected to a multilingual assistance coordinator who will be happy to assist you, 24 hours a day, 365 days a Year.

Important contact tools:
Within the United States: (800) 454-3679
Outside the United States Call Collect: (312) 935-3783
Or log on to: http://webcorp.axa-assistance.com/
Login: axa
Password: travelassist

END OF SECTION

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

JAYSON CRAWFORD, Plaintiff, vs. METROPOLITAN LIFE INSURANCE COMPANY, Defendant.	§	CIVIL ACTION NO. 3:16-CV-2402-B

DECLARATION OF JAYSON CRAWFORD

I, Jayson Crawford, declare and state as follows:

1. I am the Plaintiff in the above-entitled action. I make this declaration based on my personal knowledge.

2. I married Tracy Crawford, who was employed by Southwest Airlines, on August 15, 2011. Immediately upon our marriage, we agreed to name each other as beneficiaries and/or give each other rights of survivorship to our various individually-owned employee benefits, retirement accounts, insurance policies and other assets.

3. When we had this discussion, she told me she had designated her great-nephew as the primary beneficiary to her Southwest Airlines life insurance coverage after her divorce from her first husband, Steve Mashman, who was also a Southwest Airlines employee.

4. Pursuant to our agreement, in late 2011, Tracy told me she designated me as the beneficiary to the employee benefits she was entitled to as an employee of Southwest Airlines, including her 401(k) plan, her profit-sharing plan, and her group life

insurance coverage. She also enrolled me for medical coverage as her spouse through Southwest Airlines' healthcare plan.

5. Tracy also told me at that time that in the event she died, the life insurance plan required me to submit a claim for the proceeds within a short period of time.

6. Recently, I looked through Tracy's files to see if I had any additional documents relevant to the issues in this case other than those I already provided my attorney. I found a document Tracy received from Southwest Airlines entitled "Benefits Election Confirmation" dated November 12, 2012. A true and correct copy of that document is attached as Exhibit A.

7. Tracy unexpectedly died of a heart attack on December 15, 2014. On or about December 23, 2014, I submitted a claim to MetLife for the life insurance proceeds.

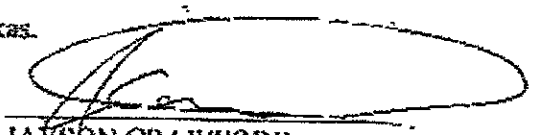
8. On April 7, 2015, I received a letter dated March 31, 2015 from MetLife requesting that I provide certified documents issued by a probate court appointing an executor or administrator for Tracy's estate. The letter also stated that until I provided MetLife with the requested documents, MetLife would place the life insurance proceeds in a holding account. A true and correct copy of that letter is attached as Exhibit B.

9. I called MetLife the same day I received the letter and spoke to a person named "Kathy" who told me MetLife had decided to pay Tracy's estate so I needed to file papers with the probate court to set up her estate and have an executor or administrator appointed.

10. On April 9, 2015, I called Kathy back to ask her questions about setting up Tracy's estate and she told me MetLife had changed its decision about paying the estate and I no longer needed to submit any paperwork in response to the letter.

11. I declare under penalty of perjury, that the foregoing is true and correct and to the best of my knowledge.

Executed on March 1, 2017, in Galveston, Texas.



JAYSON CRAWFORD